Field Readiness Assessment Report
for CalOMS
FINAL

Assessment of Field Readiness for Outcomes Measurement System

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Document Control

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Summary

The Field Readiness project is a sub project of the overall California Outcomes Measurement System (CalOMS) project, which is expanding the data that counties and direct providers are required to collect and transmit to ADP for clients receiving services from State-funded Alcohol and Other Drug (AOD) treatment programs in California. The Field Readiness project's goal is to assess the readiness of counties and direct providers for the implementation of CalOMS and the obstacles and challenges hindering their ability to achieve readiness. The information in this document was received through five regional field readiness meetings with counties (and direct providers), through the field readiness survey, and through individual county (and direct provider) conference calls.

The first phase of the field readiness assessment included holding five regional meetings to introduce the Field Readiness project, to discuss the assessment survey and to solicit input from counties and direct providers on their issues and concerns related to the CalOMS project. These meetings were held during the month of November 2003. A total of 50 counties and 13 direct providers participated in the regional field readiness meetings. In addition, some counties brought either provider representatives or third-party representatives.

From these meetings ADP received important feedback on CalOMS. Meeting participants indicated that the scale of CalOMS is too large. It is too much of an increase in data collection for counties and providers. Participants are concerned about decreasing client service and increasing waiting lists and they feel that data collection is taking precedence over treatment. For small contracted providers CalOMS requirements are overly complex and may prevent them from being able to provide services. This may reduce the number of providers in California.

Throughout the regional field readiness sessions, the following concerns were listed as the top issues facing counties and direct providers:

- Funding;
- Time;
- Complexity;
- Effect on treatment or client;
- Staff resources.

After the regional field readiness meetings, we received 57 completed county surveys and 11 completed direct provider surveys, which represent 100% of counties and 46% of direct provider corporations. We held follow-up conference calls with all counties and with 8 direct providers to clarify their survey responses.

The compiled survey results indicate the cost of CalOMS (both implementation and ongoing) as the highest concern, followed by the amount of data, the impact on treatment, the timeline, staff qualifications, and the automated data issues. The results indicate that many respondents perceive benefits from CalOMS, including providing valuable outcomes

data, providing data to improve services, and helping counties demonstrate effective use of treatment resources for grants and other future funding. The majority of respondents indicate that they anticipate significant (11 – 30%) or fundamental (over 31%) business process changes within their organization and for their contracted providers as a result of CalOMS. In addition, the majority of respondents indicate that they "maybe" or are "unlikely" to be ready for the October 2004 date. For respondents that gave an alternative implementation date, on average an additional 9 months was requested, with a range of 3 months to 48 months.

Counties report that across the State 88% of providers are county-contracted versus 12% which are county-operated. The county-contracted providers account for a little over half of the total admissions reported currently through CADDS. Counties that have county-contracted providers anticipate various contract changes with providers to accommodate CalOMS. Highlighted in the survey responses were client locator and follow-up changes, data collection and submission changes and changes to timelines for data entry. Projected span time to implement the anticipated contract changes ranged from 2 – 24 months, with the average span time of 10 months.

Results indicate that counties anticipate changes to the number of clients served by service type. When looking at specific service types, the average projected reductions range from 10% - 25%. Forty counties indicate that their Board of Supervisors (BOS) will need to approve their plan before beginning the implementation of CalOMS and that they need lead time to work with their BOS to begin to implement CalOMS. Projected lead times ranged from 2 – 24 months, with an average of 6 months reported. Many counties also report that they need emergency requirement regulations, state contract changes, and the opportunity to revise their budget for SAPT monies, as well as funding from ADP.

The majority of counties report that SAPT funds are not sufficient to cover their initial implementation expenses for CalOMS. Most counties have no additional sources of funding for CalOMS besides their SAPT funds; although 10 counties did report other sources of funding. Almost all direct provider respondents anticipate a fiscal impact from CalOMS. For some direct providers, CalOMS implementation will be complicated further because their organization acts as a direct provider in some counties and as a county-contracted provider in other counties.

Twenty-nine counties and 3 direct providers report that they use the Addiction Severity Index (ASI) on over 71% of their clients. Twenty counties and 8 direct providers report not using the ASI or using it on less than 30% of their clients. Of the counties that use the ASI, 58% use an automated ASI, while only 1 direct provider uses an automated ASI. Counties and direct providers report automation and training as the strategies that would make it easier to administer the ASI within their organizations.

Of all survey respondents, 31% indicate they do not perform follow-up on any of their clients; 69% indicate that they perform follow-up on some portion of their clients, with the majority of follow-ups performed at 3 or 6 months post admission. Only 6 respondents (9%) currently perform follow-up at the 9 months post admission timeframe required by

CalOMS. Thirty-two out of 46 small or MBA (Minimum Base Allocation) counties and direct providers are interested in participating in a county consortium for nine month follow-up sampling.

Regarding current automation, 29 counties are fully automated for CADDS transactions, while 12 counties report no CADDS automation. The other 16 counties currently submit some portion of their CADDS transactions in an automated fashion. 10 out of 11 direct providers surveyed have no current automation for CADDS transactions.

Regarding IT staffing, most direct providers have 1 – 3 IT staff members to leverage for CalOMS. For small and MBA counties, 22 out of 35 report no IT staff. Most medium counties have 1 – 3 IT staff members. Large counties report an average of 16 staff members when excluding the highest and lowest reported value. Many respondents indicate these staff members are already fully utilized on other projects.

Respondents estimated from 2 – 30 months elapsed time will be needed to modify their systems for CalOMS, with an average of 12 months needed for medium and large counties and an average of 9 months needed for MBA and small counties and direct providers. There was an overwhelming interest in participating in a county consortium for the development of an automated system, with 40 counties and 8 direct providers indicating their interest.

Survey respondents indicate that they will need training. They also have a need for ongoing training due to staff turnover and indicated that the lack of funding impacts counties abilities to train. Counties want ongoing, regional training in the proper interviewing and information gathering of CalOMS data, including informed consent, the ASI and the follow-up.

The next step for the Field Readiness project is to work with counties and direct providers to create individual readiness plans, which will identify and document the strategies and plans that each county (or direct provider) will use to achieve readiness for CalOMS. During this effort, the Field Readiness Toolkit will be distributed to counties and direct providers to assist in the readiness planning.

Purpose

ADP is expanding the data that counties are required to collect and transmit to ADP for clients receiving services from State-funded Alcohol and Other Drug (AOD) treatment programs in California. The Field Readiness project is a sub project of the overall California Outcomes Measurement System (CalOMS) project. The Field Readiness project's goal is to assess the readiness of counties and direct providers for the implementation of CalOMS.

Counties and service providers will play a major role in the success of CalOMS. Many counties and treatment providers will need to make significant changes in the way they do business when delivering AOD treatment services to clients. The expanded client data collection and reporting will also have a significant impact on the information technology infrastructure used by counties and providers to collect, manage and report client information. Due to the new Federal PPG requirements, it is critical that the counties and providers become ready to begin the expanded PPG client data collection by October 2004.

Approach

For this phase of the Field Readiness project, ADP's goal was to determine counties and direct providers readiness for an outcomes measurement system and the obstacles and challenges hindering their ability to achieve readiness. The information in this document was received through regional field readiness meetings with counties and direct providers, through the field readiness survey, and through individual county (and direct provider) conference calls.

This document represents the culmination of the field readiness assessment phase of the overall Field Readiness project.

Our approach to the field readiness assessment included gathering information through three vehicles: regional meetings, field readiness surveys, and individual county (and direct provider) conference calls. The 112-question survey was developed including input from a panel of ADP business experts. The direct provider survey included 89 questions, most of which were a subset of the county survey; however there were a few questions that were relevant for direct providers only. The surveys were tailored to each county (or direct provider) with data gathered from other ADP sources, such as CADDS and SRIS, for respondents to correct as appropriate. Surveys were mailed in hard copy and e-mailed in electronic format to all counties and direct providers on 10/17/2003. The deadline for the return of completed surveys was 12/10/2003. We received 57 completed county surveys and 11 completed direct provider surveys, which represent 100% of counties and 46% of direct provider corporations. In addition to the surveys, five regional field readiness meetings were held during November 2003 to clarify CalOMS requirements, describe and goals and timelines of the Field Readiness project and solicit input on issues and barriers.

After the regional meetings, we held individual county and direct provider conference calls to clarify survey information, paying specific attention to:

- The respondent's readiness to implement CalOMS by the October 2004 date;
- The top issues, barriers and challenges that impact or prevent readiness;
- The need for organizational changes, including business process impacts, human resources and automation infrastructure;
- The respondent's need for resources and assistance;
- Other factors related to field readiness that ADP and other counties may need to know.

We held conference calls with all 57 counties and 8 direct providers. The results in the individual county readiness assessments include information gathered from both the surveys and the conference calls whenever applicable.

Field Readiness Assessment Scope

The Field Readiness project team conducted an assessment of the 58 counties[1] and 39[2] direct provider's preparedness for the expanded client data collection and reporting as described in the CalOMS requirements documents dated October 29, 2003.

The field readiness assessment included:

- Assessment of the readiness of each county (and direct provider) individually and the counties (and direct providers) as a whole for expanded client data collection and reporting.
- Holistic assessment of county and direct provider readiness for expanded client data collection and reporting that encompasses organizational, business process and automation perspectives.
- Identification of training and technical assistance that ADP and other entities may need to provide to help counties and direct providers achieve readiness.

The scope of this project does not include an assessment of the readiness of ADP or other State entities.

Project Background

For detailed project background, please see the Field Readiness project charter included in the PMP – Field Readiness Final dated October 17th, 2003.

[1] Sutter and Yuba are combined.

[2] 39 direct provider locations represent 24 direct provider corporate entities. We surveyed direct providers at the corporate level, not at each separate provider location.

Regional Meeting Issues

Overview on Regional Field Readiness Meetings

Part of the field readiness assessment included holding five regional field readiness meetings to introduce the Field Readiness project, the assessment survey and to solicit input from counties and direct providers on their issues and concerns related to the CalOMS project. The meetings were organized geographically as well as by like-size counties and were held in Bakersfield, Santa Ana, San Mateo, Sacramento and Redding during the month of November 2003. Participation was good, with a total of 50 counties and 13 direct providers participating in the regional field readiness meetings. In addition, some counties brought either provider representatives or third-party representatives.

Bakersfield – 8 counties and 5 direct providers represented
Santa Ana – 6 counties, 1 direct provider, UCLA, and 1 Los Angeles county provider represented
San Mateo – 10 counties represented
Sacramento – 13 counties and 11 providers or direct providers represented
Redding – 13 counties and 1 third-party vendor represented

The following issues and concerns were raised and discussed during the regional field readiness meetings and are documented in the words of the meeting attendees. Based on subsequent survey results, many attendees did not have a high level of understanding on the overall CalOMS requirements when the regional field readiness meetings were conducted.

Top Issues and Concerns

- The following concerns were listed as the top issues facing counties and direct providers:
    - Funding;
    - Time;
    - Complexity;
    - Effect on treatment or client;
    - Staff resources;
    - Intake timeframe;
    - Training;
    - Data set size;
    - Standardized data collection procedures;
    - Provider evaluation concerns;
    - Prevention concerns.

- The scale of CalOMS is too large. It is too much of an increase in data collection for counties and providers. The enormity of the CalOMS changes is the issue. Is there a simpler way to do this?
- Counties are concerned about decreasing client service and increasing waiting lists (due to lack of additional funding for CalOMS).
- Counties question that data collection should take precedence over treatment.
- Counties and especially direct providers did not feel that they had input to, nor had been informed about, the CalOMS vision and requirements.
- For small contracted providers CalOMS requirements are overly complex and may prevent them from being able to provide services. This may reduce the number of providers in California.

In all of the meetings, common themes emerged: funding, privacy, systems, staffing and training, data collection, use of ASI-Lite CF, follow-up, data quality, timing and sanctions. The specific issues presented are listed under these themes, below.

Funding

- Counties want a partnership with ADP to discuss and better understand funding issues.
- Funding is needed for development of software.
- Funding is needed for staff to collect ASI and data elements.
- Funding is needed for capital expenditures, such as equipment.
- The impact of the lack of funding means that:
  - Treatment ability will be impacted; fewer clients will be treated or they will have shorter treatment times;
  - This project will impact contract requirements with providers;
  - Quality of care, access and capacity issues are of concern;
  - Further cuts might drive some providers out of business;
- Systems development and infrastructure requires a lot of money, especially considering the integration requirement with providers.
- Counties requested that ADP issue a policy letter on funding for CalOMS. Counties want a clear direction from ADP on what SAPT monies can be spent and how to account for it. What is ADP's intent on money and funding? What's required for tracking this money? Can SACPA, CalWorks or Drug Medi-Cal money be used and in what percentages?
- Funding is an issue on an ongoing basis not just at start-up.

- These are tight fiscal times. Some counties have already lost 2/3 of our discretionary spending this year. VLF (vehicle license fee) money is going away. Counties have hiring freezes.
- Counties don't have enough funding to operate, much less roll out new system. The timing couldn't be worse.
- Counties need CalOMS requirements included in State regulations. It is essential for counties to have this in order to get their vendors to comply with CalOMS and to get funding approved.
- What about direct providers, if paid for by public funds, are they required to report CalOMS data?
- Non-ADP funded admissions (i.e. CDC funded contracts with local providers or for CalWorks) – do these clients fall under CalOMS?

Privacy

- Counties have concerns with HIPAA security requirements and their ability to integrate providers and ensure HIPAA compliance.
- Counties have concerns about sharing data with other agencies. What data is shared and how is privacy ensured?
- Counties are concerned that perinatal women will not participate because of interagency data sharing and concerns that their children will be taken away from them.
- Counties are concerned about protecting their clients' privacy related to collecting client locator information, including Social Security Number (SSN) and drivers license numbers. Counties are concerned about identity theft.
- Counties expect that some clients will not fill out locator forms because of privacy concerns.

Systems

- Counties want to create a partnership to identify system issues.
- The non-centralized approach of CalOMS will increase cost to counties.
- Providing a web application from county level to providers may be a reasonable approach. However, counties may not have experience in developing web applications. IT staff training for potential web development is an issue.
- Counties are concerned with third-party vendor's (e.g. ECHO, Accurate Assessments) ability to react and implement CalOMS requirements within the expected timeframes.

- Counties are concerned with their existing systems capability to absorb all the new data elements required for CalOMS.
- AccuCare software is currently being used by some counties. AccuCare does not use the ASI-Lite CF version of the ASI. ADP should consider accepting other versions of the ASI.
- Counties requested that ADP hold technical requirements clarification sessions with counties to ensure counties understand the technical requirements and considerations before they begin development.
- For counties that don't currently have an automated data collection system, implementing CalOMS is a significant challenge.
- For small counties a web based "turn-key" application would be extremely helpful. Some counties expressed willingness to dump their local systems in favor of a state sponsored system.

Staffing and Training

- Department of Mental Health (DMH), ADP and HIPAA pose competing resource requirements on counties. There is a feeling of "we can't do another thing".
- Counties are concerned with the delivery, availability and their ability to train program staff.
- Training on how to improve quality of delivering care is needed.
- Counties recognize the need for staff to interact and communicate with other agencies regarding referral support.
- Counties are concerned about staffing for follow-ups, including training staff to gather thorough responses.
- Staff morale will be affected by the implementation of CalOMS.
- For small counties, staff members already do too much multi-tasking and feel they can't do more.
- Some staff members are resistant to using automated tools when interviewing clients. They think therapeutic quality is compromised with the use of computers. Not all AOD staff members are comfortable with using computers.
- CalOMS training is offered on a one-time basis only. This does not address need for ongoing training.
- The sampling methodology has a potential impact on provider staffing for follow-ups. If providers perform the follow-ups (as opposed to performing

them at the county level,) providers will potentially have an inconsistent follow-up workload per sampling period.

Data Collection

- The volume of CalOMS data is too high. Scale of data collection impacts staffing and clients. Counties are concerned about the impact of CalOMS data collection at the provider level, provider's ability to collect data, the volume of data, and applicability of data (is ADP asking the right questions to get correct outcomes data). The amount of time needed to work with clients to collect the data is too much. Data entry is a challenge. The time needed for follow-up is too much.
- Counties expressed concern over whether clients will be willing and able to have such a long intake. Some clients will not be able to focus and respond during a long interview. CalOMS may not be feasible to implement from a client perspective.
- Counties are concerned about error correction capacity and auditing of reported data.
- Counties are not clear on ADP's vision for CalOMS data collection. What is expected for integrating changes into the county systems? What are the timeframes and what is the file layout? Counties want more specifics.
- How do counties handle the client that moves from site to site? This issue results in redundant data collection, which is a burden to clients, providers and counties.
- Short-term clients may end up being mixed in with other clients. ADP may want to qualify clients based on services for the ASI-Lite CF collection. Client drop out rates are an important consideration.
- Counties don't have enough people or money to do this. Can AOD work with DMH to collect questions that overlap and/or to standardize data?

Use of ASI-Lite CF

- ASI data elements will be a burden. Counties recommend scaling this down.
- The amount of data collected will be burdensome to the client as well. Counties are concerned that AOD treatment receivers (clients) have not been involved in the requirements gathering phase.
- One county estimates they will be able to treat about 8% fewer clients due to the additional time required to collect ASI data and to perform follow-ups. The ASI-Lite CF and follow-up are being asked for, and it seems like

counties don't have a say. Counties question the fact that requirements are set and there is no negotiating or discussions on this point.

- There is a need to conceptualize a new paradigm of treatment and the issue of collecting ASI data. All other data elements are reasonable. Counties are worried about the quality of the ASI data and amount of time it is going to take to collect it.
- Collecting ASI data will be difficult due to time limit and staff capabilities. If DMH Client and Service Information system was used it might make more sense.

Follow-up and Sampling

- Counties expressed concerns that they won't be able to do 10% follow-up successfully. They won't find the 10%. Many clients will not be willing or able to participate. Significant staff time will be needed to perform follow-ups.
- Unless the stratified sampling is in place, there is a selection bias at the county level. That selection bias could bias the outcomes study.
- Counties are concerned that the sampling methodology will not enable them to get valid outcomes data at the provider level.
- CalOMS should be client focused. It is not feasible from a client perspective.
- Someone from the county will need to do the follow-up (not the provider) because the sampling occurs at the county level and not the provider level.
- Administering ASI on follow-up as opposed to admission is only 9 data element difference. It will be challenging to do 136 questions at follow-up.
- No financial incentives in CalOMS will also impact ability and success of follow-ups.
- Would ADP consider making follow-up a state responsibility and take it out of county realm? This would really help counties.
- Can sampling be done up front so that ASI is collected only on those clients that may be a part of the followed-up set (25%)?
- Counties requested stratified sampling based on modality. Is there information on multiple treatment episodes and treatment effectiveness with certain groups? No service data being gathered will make it difficult to compare outcomes.
- Will future funding be impacted by county ability to perform follow-ups?

Data Integrity and Quality

- Without centralizing CalOMS data collection, how will CalOMS data collection be consistent? Inconsistent data values and data sets exist across systems. It will be difficult to extract data out of various systems and data quality may suffer. Clear definitions are needed at the beginning of this project to prevent this problem.
- Counties suggested a pilot program or project to test data relevance and quality. Feasibility for providers to perform data collection should also be tested. This project hasn't been tested in a real world environment.
- Counties want to assure the data integrity of CalOMS will be high.
- There are compatibility issues of the ASI instrument between various vendors, e.g. DeltaMetrics, AccuCare, etc… which could result in data inconsistency.
- Counties want to know when quality data will be provided back to counties.
- Counties have data integrity concerns due to the length of instrument and data collection processes.
- Staff members collecting ASI data are non-licensed. This has potential impact on the quality of data.
- Counties are concerned that the validity of the ASI breaks down with dual diagnosis.
- The consistency of administering the ASI across counties is required to get reliable outcomes. There is a critical need for clear definitions prior to implementation of CalOMS to ensure data quality.

Timing of implementation

- Direct providers are concerned that they will not have money and/or capabilities in the timeframe to customize software and to acquire needed hardware.
- Even if funding is available, to expect counties and direct providers to have systems ready within 1 year is aggressive.
- Counties need lead time for operational changes. New business processes will have to be setup. Counties need to look at business model with implementation because opportunities exist for process improvement. Time is needed to setup quality processes rather than focus solely on implementation.
- A consortium of ECHO counties is currently in the process of issuing an RFP (01/2004) – CalOMS needs should be incorporated. For counties participating in the consortium, the 10/2004 timeline is not reasonable.

- CBS coalition – some counties already have efforts underway to create new systems, such as the CBS coalition. CalOMS will have a development impact on these new systems, which are not planned to implement on or before October, 2004.
- Counties are concerned about complying with these CalOMS treatment requirements as well as the prevention requirements, which have not been determined at this point. Counties are concerned about being able to react to and implement prevention requirements, considering the other issues counties are facing during the same timeframes.
- If PPG requirements are driving the October 2004 date and the timeline for the data collection is so tight, is there a possibility for phasing in the CalOMS data gathering requirements and still meeting the limited Federal data requirements?
- Administration change (at state level) introduces unknowns. Counties may delay action because direction may become unclear as a result.
- Current fiscal year implementation impacts may need to go back to Board of Supervisors, which will cause local political issues.
- We need to scope this project appropriately. It is too big over too short a time.
- Lead administrative time is needed for re-negotiating contracts for dollars and funding. Contract changes will be a significant effort and represent a barrier for counties.
- The budget process starts in December and budgets are submitted in March. ADP can't expect counties to change on a dime.
- For smaller counties the time frame for implementation is not reasonable.
- It will be hard for counties to get support (IT and fiscal) to implement CalOMS.
- Is there a contingency plan for satisfying the PPG requirements and/or for CalOMS?

Sanctions

- Counties want to know if there will be sanctions for non-compliance to CalOMS requirements or timeframes. Will there be sanctions for not completing the 10% follow-ups?
- Counties want to understand any fines or fees for non-compliance.

Other Issues

- Direct service providers function differently across counties. They may act as a direct provider for one county and as a county-contracted provider for another county. This fact may make data collection for CalOMS difficult and complicated for some direct providers.
- Will providers get their needs met? Ultimately usable information needs to get back into the hands of the clinicians to improve treatment.
- Should focus be on retention rather than follow-up?
- Counties are concerned that they will have multiple reporting points to ADP.
- It is a concern to providers that provider performance information will become public. How will providers be measured? (How long are you retaining clients? Graduation rate? Recidivism rate?) What is ADP looking for?
- Counties are concerned about the disparity of goals: SACPA aims to maximize treatment while CalOMS will require drawing money away from treatment. Counties are under pressure from judges to increase intake and decrease waiting lists. CalOMS will make this goal extremely difficult to meet.

Survey Results

For information about the survey development and approach, please see the Approach section of this document. *This section should be printed in color because the charts and graphs may not be readable in black and white.*

MRC received 57 completed county surveys and 11 completed direct provider surveys, which represent 100% of counties and 46% of direct provider entities.

The following sections highlight specific results found in the surveys. When specific questions are indicated, the question numbers refer to the county survey; the corresponding direct provider survey numbers are referred to in parentheses, if applicable.

Throughout this section, totals, percentages, averages, medians or modes were used to interpret the data. Depending on the question and the data, the most appropriate method was used.

Section Definitions

Average – "A number that can be regarded as typical of a group of numbers, calculated by adding the numbers together and then dividing the total by the amount of numbers."

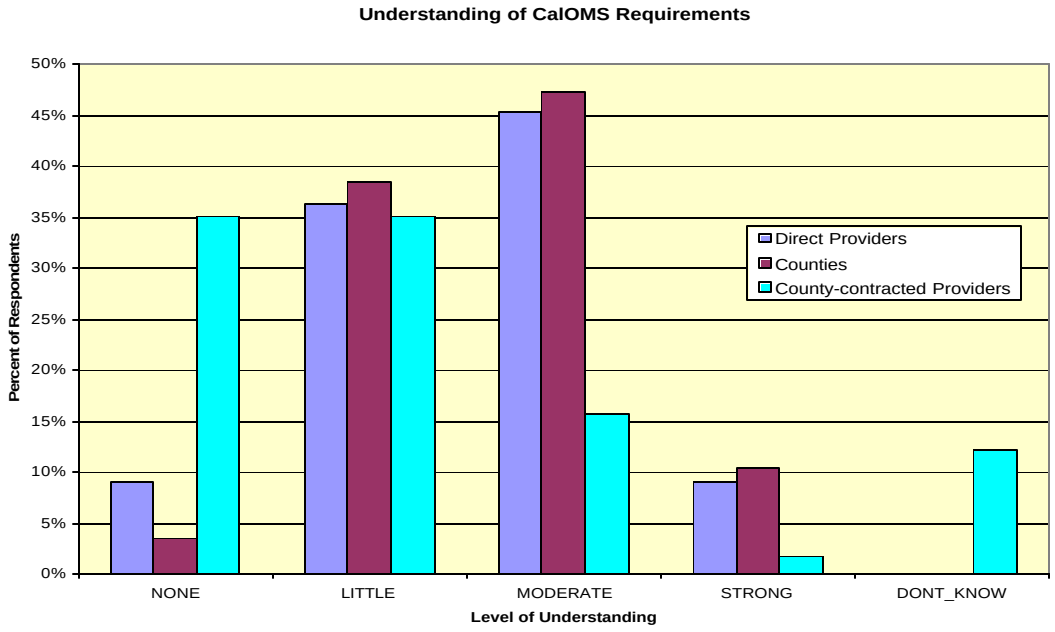
Median – "The middle value in a set of values that are arranged in ascending or descending order."

Mode – "The value that has the highest frequency within a statistical range."

Overall CalOMS Concerns

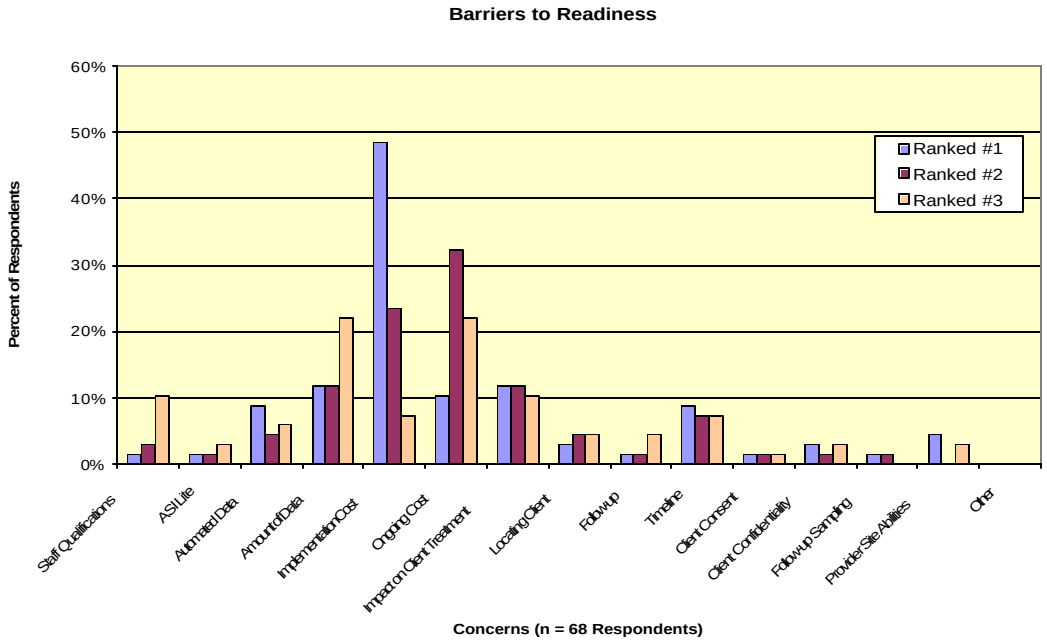
QUESTIONS 1 AND 2 (1) – "Our county understands (or our providers understand) the data and operational requirements to implement CalOMS..."

The survey results show significant differences in the level of understanding of the data and operational requirements to implement CalOMS between counties and their report of their providers, as shown in the following graph. Direct providers responses are also shown. The majority of county-contracted providers were reported to have little or no understanding of CalOMS requirements.

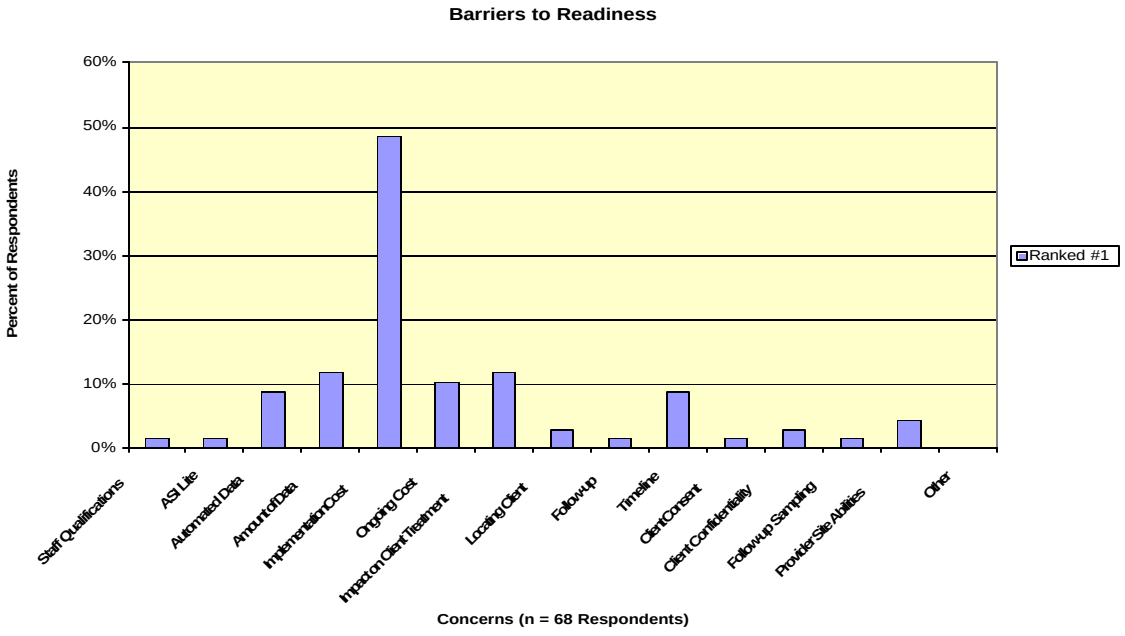


QUESTION 3 (2) – "Rank your five greatest concerns about implementing CalOMS."

The following graph shows the potential concerns, as ranked by counties and direct providers. The graph shows the costs (both implementation and ongoing) as the highest concerns, followed by the amount of data, the impact on treatment, the timeline, staff qualifications, and the automated data issues. The top three rankings are shown.

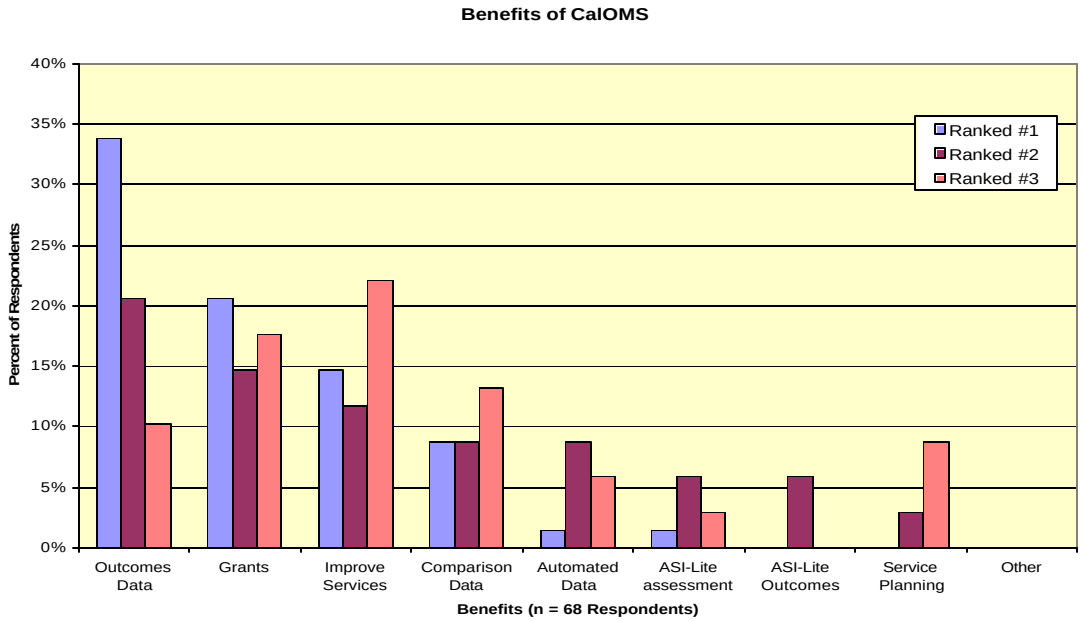


This second chart shows the number 1 ranked barrier only.

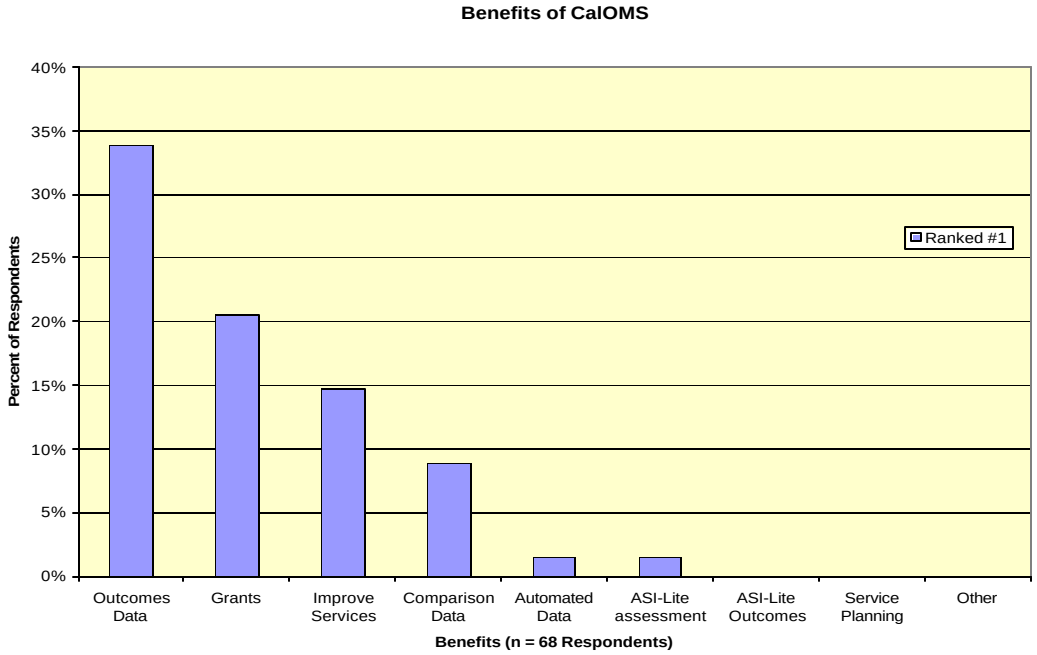


QUESTION 4 (3) – "Rank the county perceived benefits of CalOMS."

The following graph shows the top perceived benefits, as ranked by counties and direct providers. They include providing valuable outcomes data, providing data to improve services and helping counties demonstrate effective use of treatment resources for grants and other future funding. The top three rankings are shown.



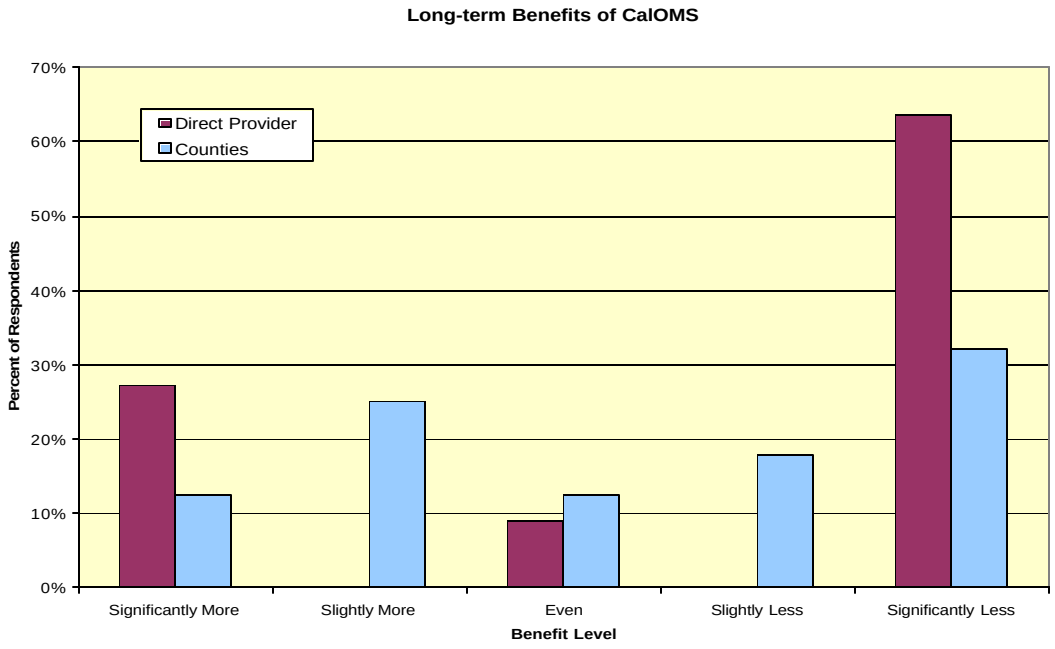
This second chart shows the number 1 ranked benefit only.



QUESTION 5 (4) – "Rate the perceived overall long-term benefits to AOD treatment that CalOMS will provide."

The following graph shows the perceived benefits, broken out by counties and direct providers, with "the benefits of CalOMS significantly outweigh the anticipated work effort"

on the left-hand side ranging to “the benefits of CalOMS are significantly less than the anticipated work effort” on the right-hand side.



The majority of respondents indicated that they anticipate significant (11 – 30%) or fundamental (over 31%) business process changes within their organization and for their contracted providers resulting from CalOMS.

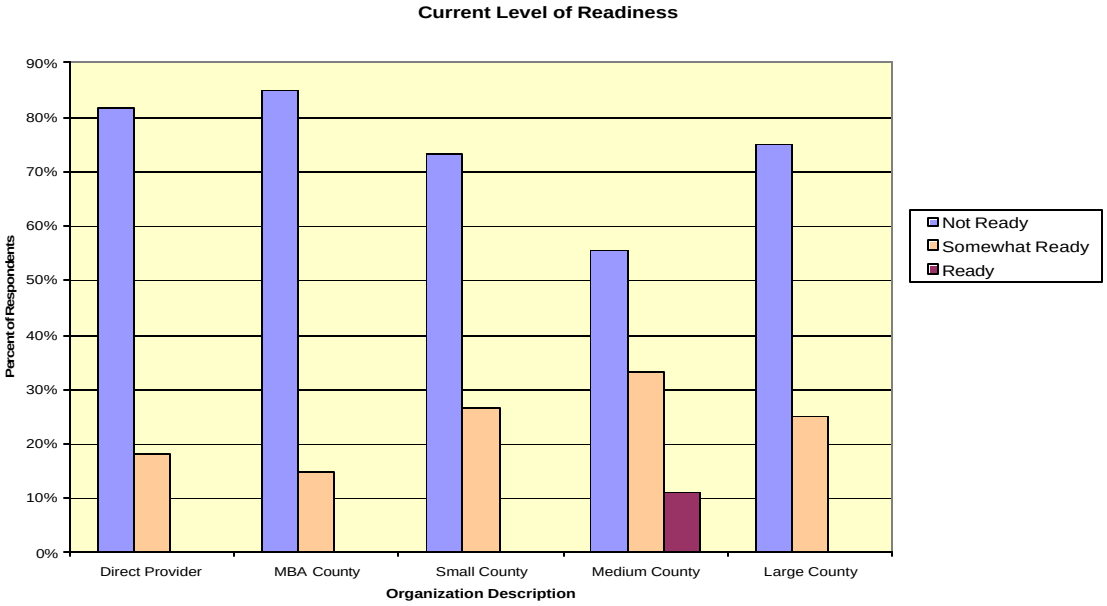
QUESTIONS 8 and 9 (6) – “In order to implement CalOMS what do you project is the cost to your county (or your providers per provider) in monetary amount (first year)?”

Organization Description	Monetary range	Average	Number of respondents
Direct Provider	$7,500 - $149,760	$40,000	8 out of 11
MBA County	$16,500 - $80,000	$45,700	9 out of 20
MBA County Providers	$50,560	$50,560	1 out of 20
Small County	$20,000 - $500,000	$155,000	10 out of 15
Small County Providers	$7,500 – $240,000	$110,000	9 out of 15
Medium County	$70,000 - $332,000	$160,000	8 out of 10
Medium County Providers	$40,000 - $450,000	$197,500	4 out of 10
Large County	$100,000 - $600,000	$350,000	7 out of 12

Large County Providers	$320,000 - $7,500,000	$1,800,000	6 out of 12

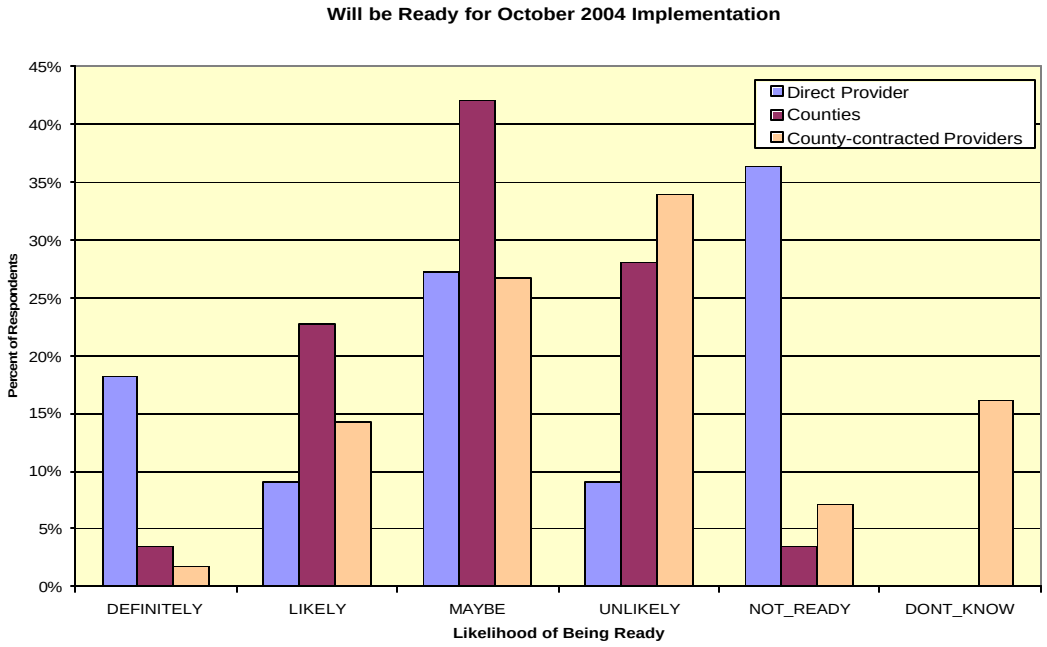
QUESTION 10 (7) – "Rate your county's and contracted provider's current level of readiness for CalOMS."

The following graph shows the respondents perceived current level of readiness for CalOMS.

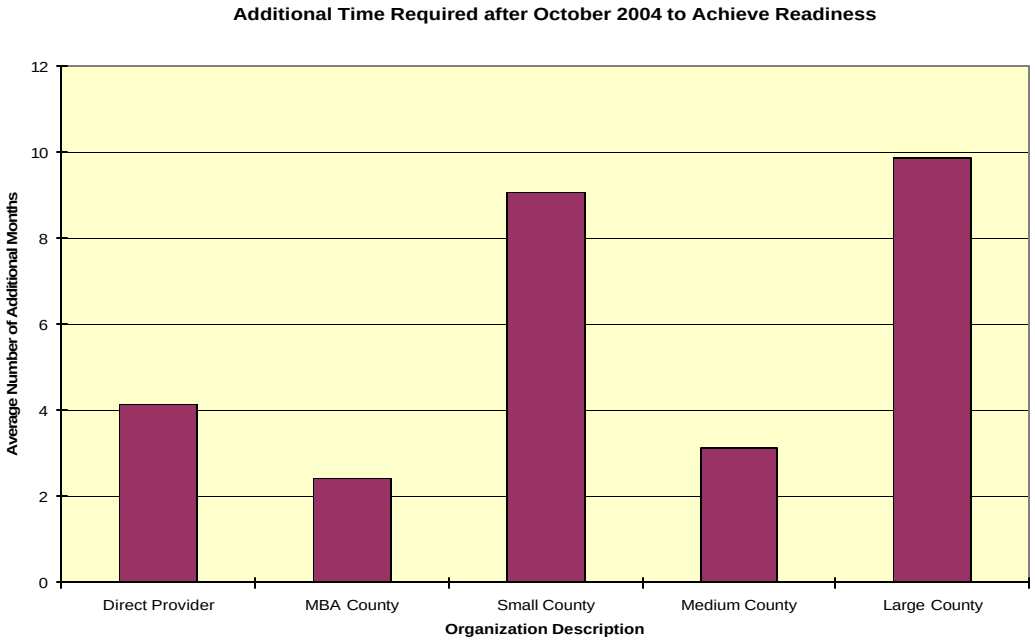


QUESTIONS 11 and 12 (8) – "Do you anticipate that your county (your providers) will be ready for the October 2004 implementation date?"

The following graph shows the responses, broken out by counties, their report of their providers, and direct providers. The majority of respondents indicated that they "maybe" or were "unlikely" to be ready for the October 2004 date.



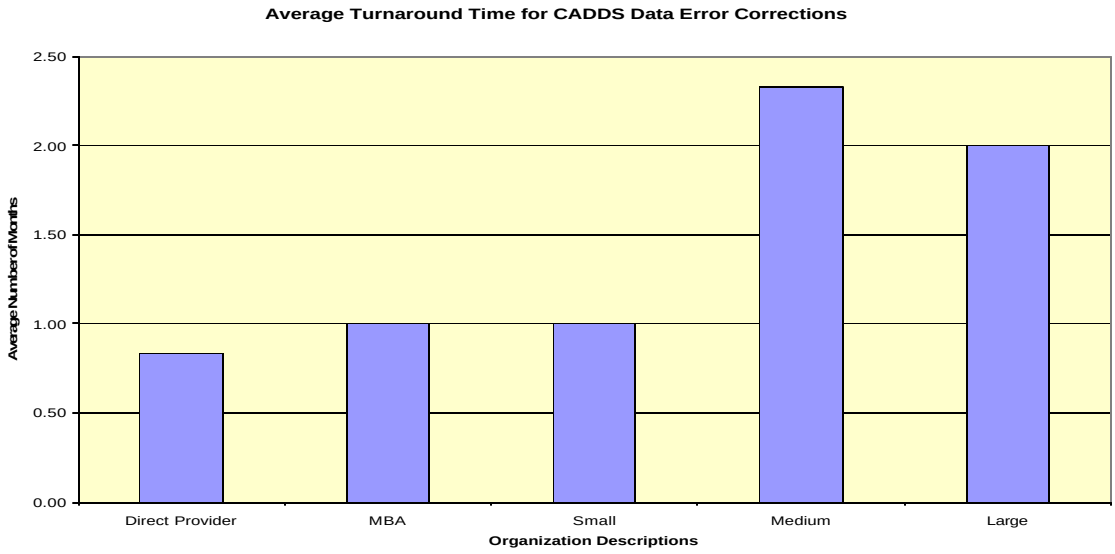
QUESTIONS 13 (9) – "If you do not anticipate complete readiness by October 2004, please specify a feasible alternate implementation date for your county, including providers."



n=11 **n=20** **n=15** **n=10** **n=12**

Current Information

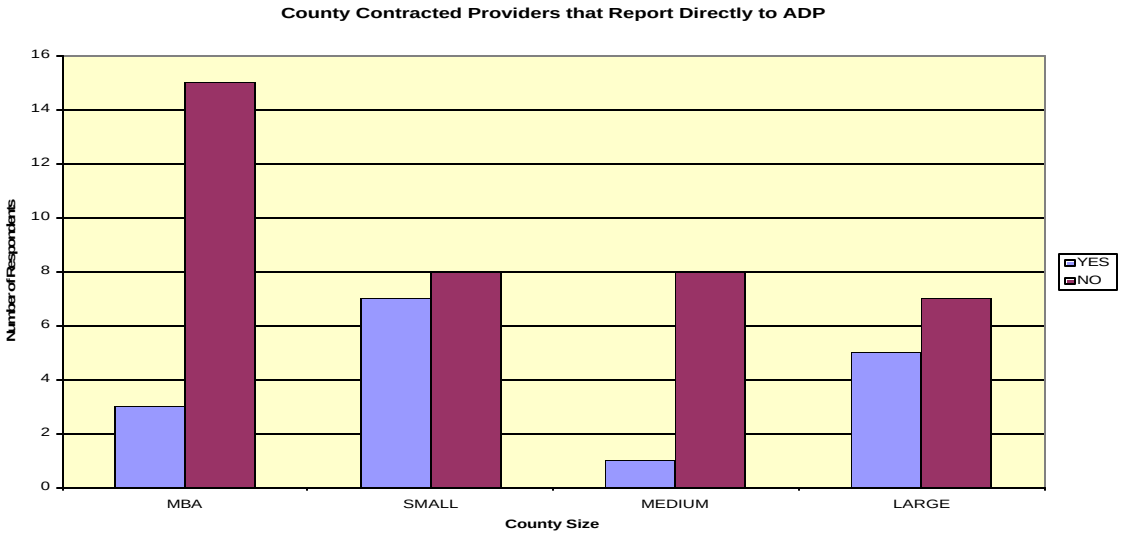
We asked for respondents to report on the average turnaround time for CADDS error corrections in months. These averages are based on the total number of respondents who answered this question because many respondents left this question unanswered.



Administrative / County Contracts with providers

QUESTION 19 – "Are there providers in your county (other than direct providers) who do not report CADDS through the county, but report directly to ADP?"

16 counties reported "yes" to this question.



Counties report that across the State 88% of providers are county-contracted versus 12% which are county-operated. The county-contracted providers account for a little over half of the total admissions reported currently through CADDS.

Counties that have county-contracted providers anticipate various contract changes with providers to accommodate CalOMS. Highlighted in the survey responses were client locator and follow-up changes, data collection and submission changes and changes to timelines for data entry. Additionally one county commented that they might possibly require contractors to track funding sources by cost center.

Projected span time to implement the anticipated contract changes ranged from 2 – 24 months, with the average span time being 10 months.

The majority of counties responded “yes” or “maybe” that they anticipate changing contract amounts with various providers as a result of CalOMS.

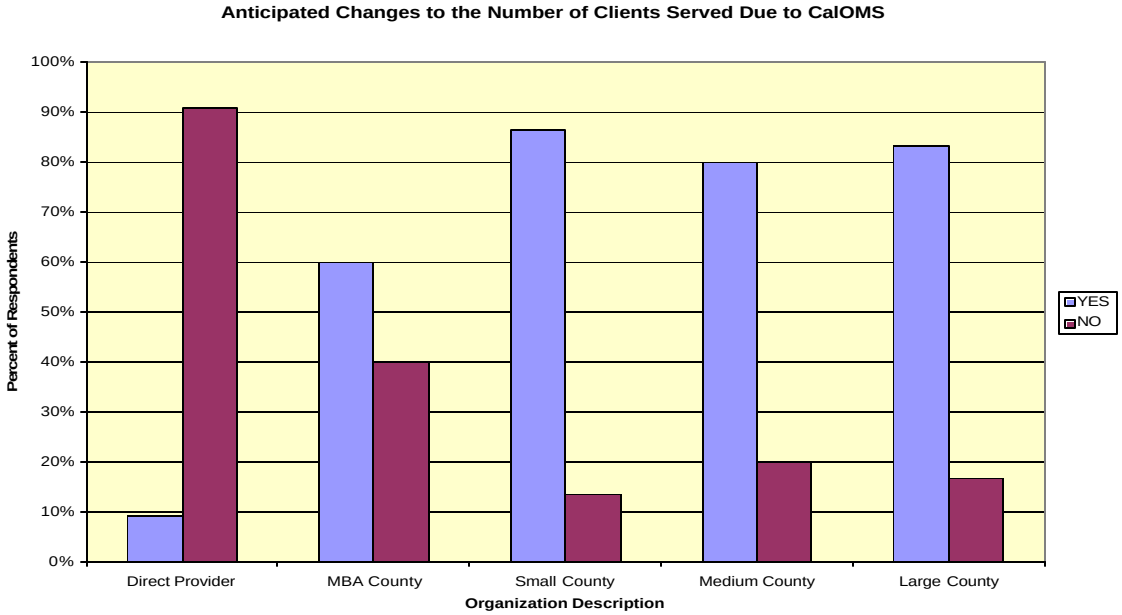
Roughly half of the respondents report an impact of CalOMS on Drug Medi-Cal (DMC) claims. Following are some of the respondent’s comments about a DMC impact from CalOMS.

- CalOMS requires multiple visits at admission, discharge, and follow-up that may not be billable with current DMC regulations.
- If staff positions are lost in order to fund CalOMS, fewer clients will be served which may decrease DMC claims.
- CalOMS requires an on-going assessment process, yet DMC only allows us to bill for one assessment; DMC does not allow for follow-up; DMC SMA does not allow for additional costs. CalOMS would require an amendment to Title 22.
- The number of billable intake sessions may increase due to the amount of data being collected.

- DMC pays for only certain individual sessions. There would be no Medi-Cal reimbursement for additional time to collect data for Medi-Cal clients.
- As a result of the additional service requirements, we will have to identify another way to pay DMC claims/clients.
- CalOMS requires that unbillable services (assessment) be provided to DMC clients. The assessment is longer than maximum billable minutes. In addition, follow-up assessments are not billable.

Question 26 (17) – "As a result of CalOMS, do you anticipate changes to the number of clients you will serve by service type?"

The graph indicates the responses, broken out by county size and direct providers. In all cases, except for direct providers, the "yes" respondents outweigh the "no". When looking at specific service types, the average projected reductions range from 10% - 25%.



Forty counties indicated that their Board of Supervisors (BOS) will need to approve their plan before beginning the implementation of CalOMS. Counties reported that they will need lead time to work with their BOS or County Administrative Office to begin to implement CalOMS. Projected lead times ranged from 2 – 24 months, with an average of 6 months reported. Many counties also report that they need emergency requirement regulations, state contract changes and the opportunity to revise their budget for SAPT monies, as well as funding from ADP.

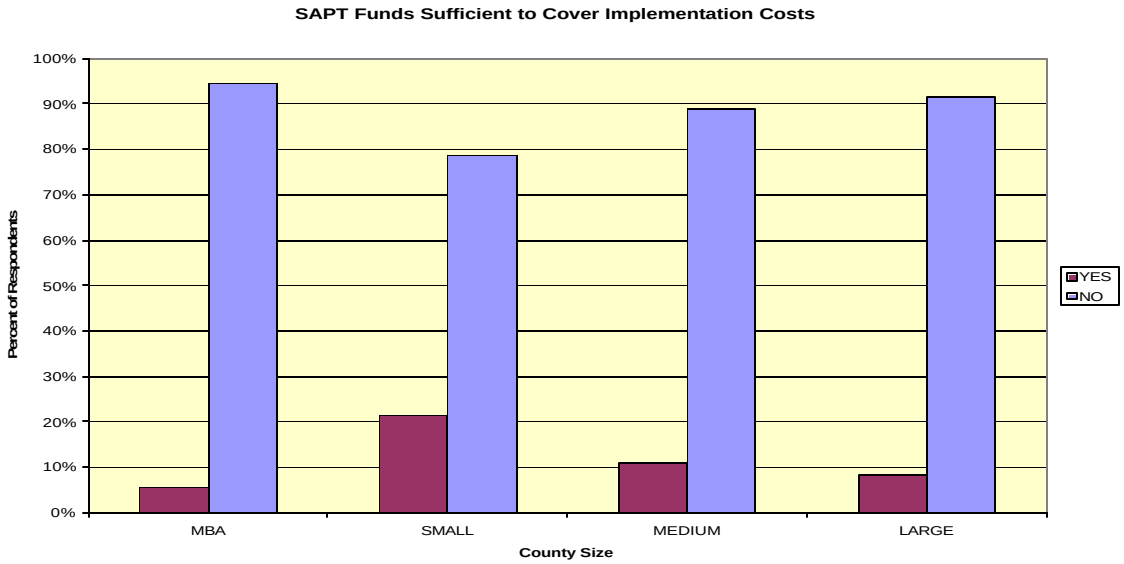
Following are some of the comments counties made regarding BOS approval.

- We assume that additional staffing positions will be required, and these will need BOS approval. Any increases to allocation associated with these positions require

BOS approval. Changes to existing contracts with providers will also require BOS approval.

- The BOS would have to approve the expenditure for software or other implementation costs.
- The BOS will have issues with reducing direct treatment services and the overall impact on administration to implement a data collection system.
- The BOS has an established specific policy addressing unfunded state or federal mandates, (board policy m-13).
- We expect some complaint from providers to Health Commission & BOS about reducing client services and reducing provider contracts.
- Funding – the issue is that the cost of this will have to come out of existing resources, which is a major issue given the static and in some areas declining resource base.
- Privacy – there are some issues about the importance of observing 42CFR and HIPAA within a large statewide database.
- Timeframe – this is a major issue because there is not readiness in the field.

The majority of counties report that SAPT funds are not sufficient to cover their initial implementation expenses for CalOMS. Most counties have no additional sources of funding for CalOMS besides their SAPT funds; although 10 counties did report other sources of funding.



Almost all direct provider respondents also anticipate a fiscal impact from CalOMS. For some direct providers, CalOMS implementation will be complicated further because their organization acts as a direct provider in some counties and as a county-contracted provider in other counties.

Admission/Intake

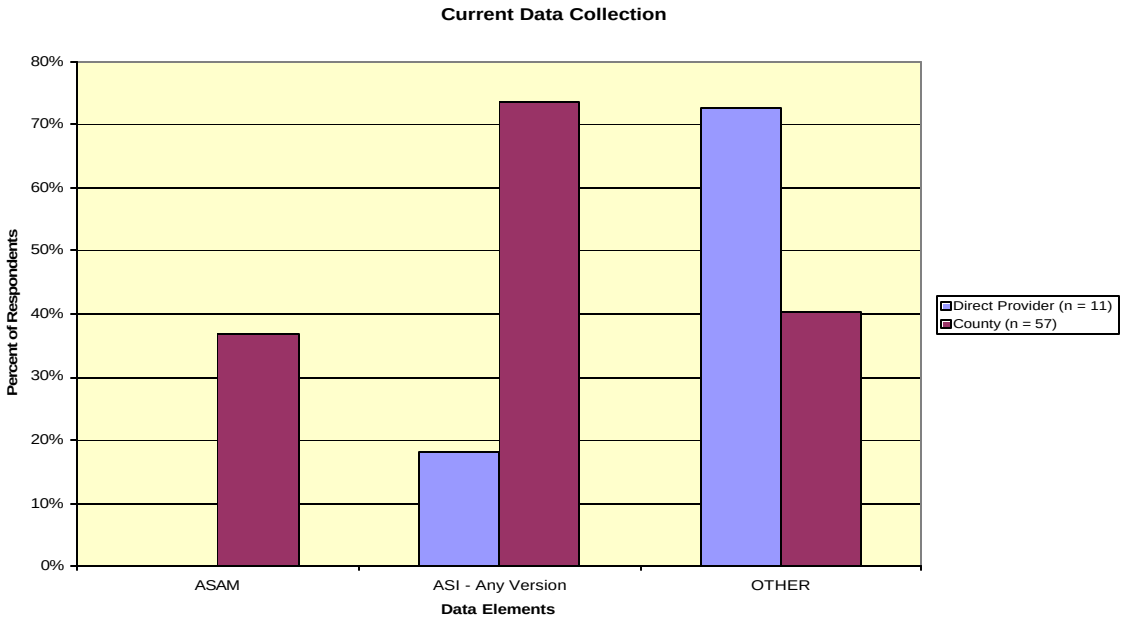
The majority of counties and direct providers report that they collect the client's full Social Security Number (SSN) at intake or admission. Respondents report that fewer than 10% of clients typically refuse to provide their SSN, for a variety of reasons. Barriers to collecting the SSN are reported as:

- With the other information being requested (e.g. UCI's,) clients may feel a breach in confidentiality.
- Some clients report false or incorrect SSN's or another person's SSN.
- Clients are concerned about identity theft.
- Some counties expect client refusal rates to increase with CalOMS.
- Clients may be reluctant to share their SSN because of distrust of people and institutions.
- We provide services to adolescents (12 - 20 years old). The majority of the time they do not know their social security numbers, and they don't want to ask their parents for them.
- Some counties anticipate fear of reprisal for undocumented immigrants.

The majority of respondents collect the client's birth name and address at admission or intake, but do not collect the client's mother's first name.

QUESTION 41 (26) – "In addition to the current CADDS data elements, do you collect any of the following data at admission or intake?"

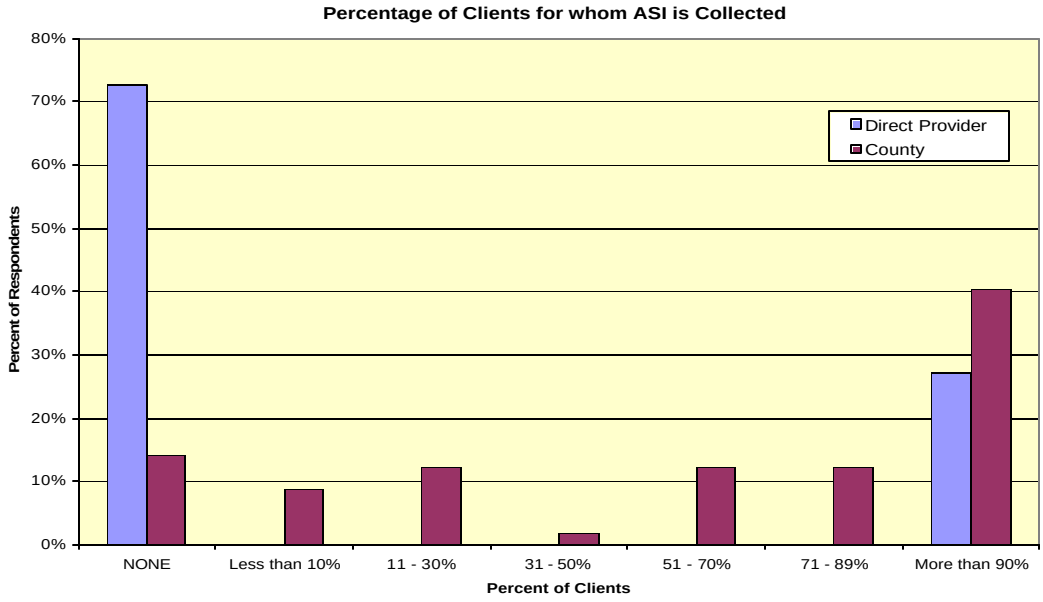
The following graph shows the number of respondents that collect the ASAM, the ASI (any version) and other data, broken out by counties and direct providers.



Addiction Severity Index (ASI)

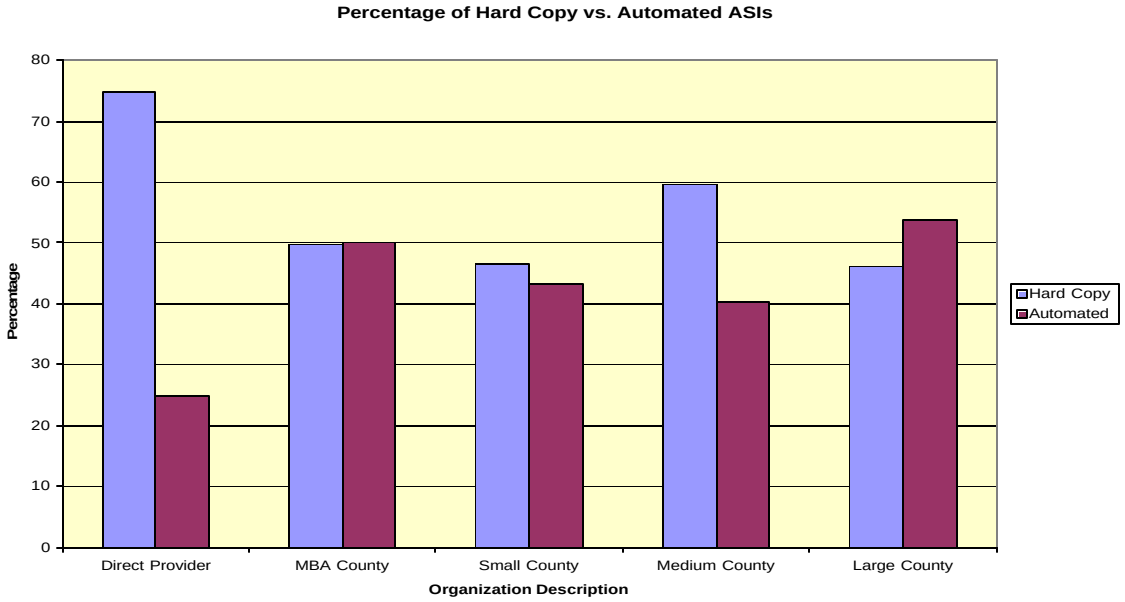
QUESTION 42 (27) – "For what percentage of your clients does your county require the use of the ASI (any version) during the course of treatment?"

The following graph shows the percentage of clients for whom the ASI is required, broken out by counties and direct providers.



Out of the 45 counties that use the ASI, 34 counties report that they calculate the composite scores on the ASI, and 34 counties report that they calculate clinical factors (not the same exact set of counties). Respondents that do not use the ASI on all clients report a variety of reasons including, not all of their county's providers use the ASI, they use a different instrument, it takes too long to administer, it is not mandated and/or ASI used depends on the program. Some counties report that they are working toward implementing the ASI for all clients. Of the counties that use the ASI, 58% use an automated ASI, while only 1 direct provider uses an automated ASI.

The following graph shows the percentage of automated versus hard copy ASI's, broken out by county size and direct providers.



Respondents cited the following barriers to administering the ASI:

- The client's willingness to answer questions, the time it takes to conduct the ASI, and difficulties collecting accurate data from the client;
- The ASI takes too much time to administer.
- Counties report automation problems when administering the ASI.
- Counties report that some providers are resistant to using the tool because of lack of resources and time.
- The ASI is often more complex than clinically required.
- Use of the automated version tends to be impersonal.
- Counties report that keeping staff trained is a barrier.
- Counties report difficulty obtaining electronic versions from providers.

Respondents cited the following benefits to using the ASI:

- It is effective for assessing needs of client.
- It is universally accepted.
- It aids in treatment planning.
- When properly administered, it provides uniform data.
- It can provide good outcomes data.

Counties and direct providers report automation and training as the strategies that would make it easier to administer the ASI within their organizations. Some respondents comment that if it were a state mandate, it would be easier to implement. Sixteen respondents that do not currently use the ASI report that they plan to implement its use in 2004.

Centralized Intake and Locator Information

The majority of respondents indicate that less than 30% of their clients move between treatment sites within one service delivery experience.

40% of respondents collect locator information on most of their clients (over 90% of clients); 27% indicate that they collect locator information on no clients or less than 10% of their clients. For organizations that collect locator data, the most common data items collected are client address, date of birth, phone number and SSN. The majority of respondents indicate that they collect locator information at admission or intake.

Client Case Management

The majority of counties and their providers use paper files to conduct client case management. Forty-six counties report that they coordinate client case management across different disciplines (mental health, social services, employment…etc.) Most counties use paper files and staff assigned to integrate client care in order to coordinate client case management across different disciplines.

Continuum of Care

Forty-two counties currently track some portion of their clients from provider site to provider site. Twenty counties follow over 90% of their clients. Most use a county assigned unique identifier to track the clients. Nine counties currently use the SSN for this kind of tracking.

Discharge

The majority of counties currently define discharge using the CADDS definition (82%). Direct provider's definition of discharge was less consistent than counties.

Length of Stay

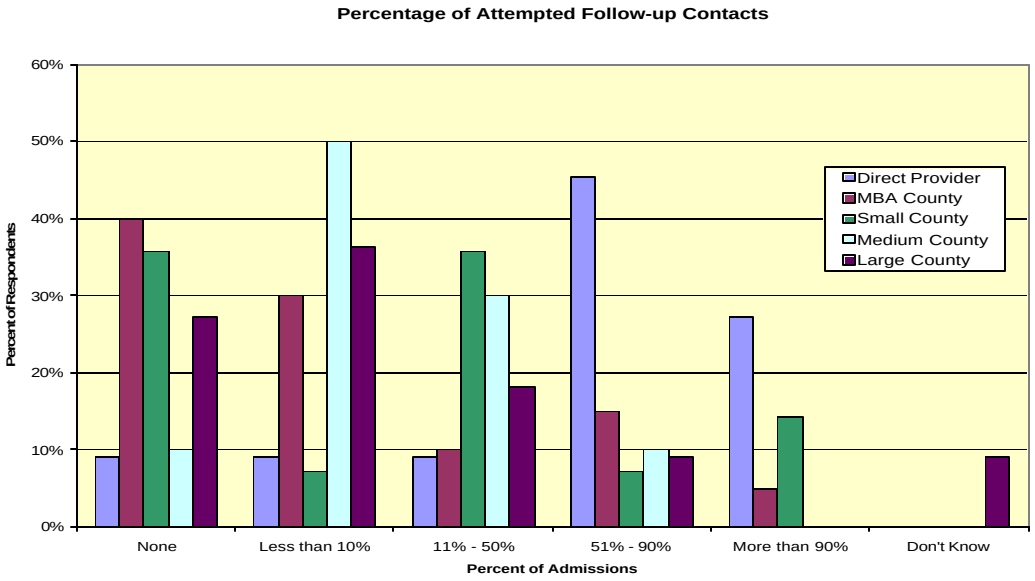
The average percentage of clients who are still in treatment after 6 months was 35% across all counties and direct providers. The median was 28%. Six months was chosen

because of the new PPG requirement within CalOMS to collect data at 6 months if the client is still in treatment.

Follow-up

The survey asked if counties or direct providers performed follow-up of any kind. Of all survey respondents, 31% indicate they do not perform follow-up on any of their clients. 69% indicate that they perform follow-up on some portion of their clients. Only 6 respondents (9%) currently perform follow-up at the 9 months post admission timeframe required by CalOMS. Some counties perform follow-ups at multiple points in time and use various methods. Most respondents perform telephone follow-ups (67%). The majority of respondents perform follow-up at 3 or 6 months post admission.

QUESTION 68 (48) – "What percentage of your admissions does your county or provider group attempt to do follow-up contacts?"



27% of respondents indicate less than 10% of their follow-up contacts are successful (client was contacted,) while an additional 41% indicate 11 – 50% success. Many respondents didn't know their actual success rate for follow-ups. The majority of respondents do not offer client incentives for follow-ups. There were 5 counties and 3 direct providers who do offer follow-up incentives. There was no correlation between incentives offered and reported success rates.

Respondents indicate an average of 7 days span time to perform follow-up on clients who are currently in treatment and 18 days for clients who are no longer in treatment. They also report an average of 39 staff minutes for clients in treatment and 46 staff minutes for clients who are no longer in treatment. For CalOMS, respondents anticipate needing on average 15 days span time and 110 minutes staff-time per follow-up.

Most respondents indicate that they assess client satisfaction at follow-up and some collect CADDS questions. Eleven respondents use an ASI or subset of the ASI at follow-up.

Respondents listed the barriers that they experience when performing follow-ups as problems with locating clients due to the mobility of clients, client's defensiveness if they've relapsed, inaccurate or incomplete locator information, and lack of staff time and/or funding. The longer the time between discharge and follow-up, the harder it is to locate the clients.

Respondents report strategies to get more participation in the follow-up process as: increasing ongoing contact with clients, financial incentives for clients, and more staff training. Nine out of 11 direct providers, 15 out of 19 MBA counties, and 7 out of 13 small counties are interested in participating in a county consortium for nine month follow-up sampling.

Automation

Twenty-nine counties are fully automated for CADDS transactions, while 12 counties report no CADDS automation. The other 16 counties currently submit some portion of their CADDS transactions in an automated fashion. Ten out of 11 direct providers surveyed have no current automation for CADDS transactions.

Regarding IT staff, most direct providers have 1 – 3 IT staff members to leverage for CalOMS. For small and MBA counties, 22 out of 35 report no IT staff. The small or MBA counties that have IT staff generally have a partial position up to 2 staff members. Most medium counties have 1 – 3 IT staff members. Large counties report a range from 0 – 300 IT staff, with an average of 16 staff members when corrected for the highest and lowest reported value.

Most respondents expected to use 1 – 3 systems for collecting and reporting data to ADP for CalOMS. Respondents estimated from 2 – 30 months elapsed time needed to modify their systems for CalOMS, with an average of 12 months needed for medium and large counties and an average of 9 months needed for MBA and small counties and direct providers.

The overall projected average monetary amount needed to analyze, design, develop and implement system changes is $135,575. This average for medium and large counties is $245,625, while for MBA and small counties and direct providers it is $67,852. Twenty-six respondents indicated "don't know" for the monetary estimates.

Thirty-one survey respondents estimated an average of 10 months span time needed to acquire outside vendors for support the CalOMS implementation. Forty respondents currently use the Department of Mental Health's ITWS portal; 28 respondents do not currently use ITWS.

There was an overwhelming interest in participating in a county consortium for the development of an automated system that could be used by many, with 40 counties and 8 direct providers indicating their interest.

Communication

Counties reported that they most frequently maintain communication with their providers by face-to-face discussions, phone calls or e-mail. The majority of counties (47) reported that they are mostly or completely satisfied with the level of communication that they currently have with their providers.

Counties and direct providers reported that they mostly maintain communication with ADP through association meetings, phone calls or e-mail, as well as through ADP's website. The majority of counties and direct providers (56) reported that they are mostly or completely satisfied with the level of communication that they currently have with ADP. However, there are 13 respondents that are minimally or not satisfied with their current level of communication with ADP.

Training Issues

Counties and direct providers reported training needs for CalOMS that are summarized in the following table.

Type of Training	Range of users needing training (per respondent)	Total across survey respondents	Number of surveys unmarked
CalOMS/ITWS	2 – 325	1,209	3
ASI-Lite CF	0 – 1,000	3,782	9
ASI-Lite CF refresher	0 – 600	2,054	18
Locator form	2 – 1,000	3,889	13
Locator form refresher	0 – 1,000	1,560	41
Follow-up	2 – 275	1,622	22
Follow-up refresher	1 – 289	727	36

Comments from survey respondents included bringing up the need for ongoing training due to staff turnover and indicating that the lack of funding impacts counties abilities to train. Some counties want to continue to use the full ASI and therefore do not want ASI-Lite CF training. Some counties comment that the more training ADP can offer, the better. Counties want ongoing, regional training by ADP in the proper interviewing and information gathering of CalOMS data, including informed consent, the ASI and the follow-up. Some counties suggested that ADP supply a video to help meet ongoing training needs.

Toolkit

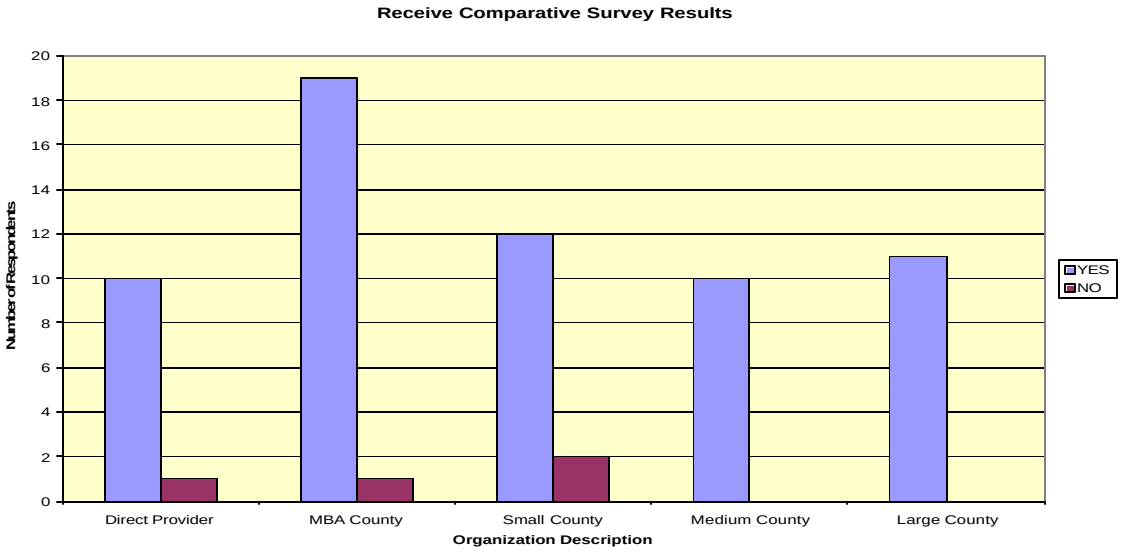
In this section survey respondents were asked to give us ideas on items that ADP could provide to help them with CalOMS issues. Results from this section are included in the Final Field Readiness Toolkit.

Survey Feedback

In this section survey respondents were asked to give us feedback on the Field Readiness survey instrument itself.

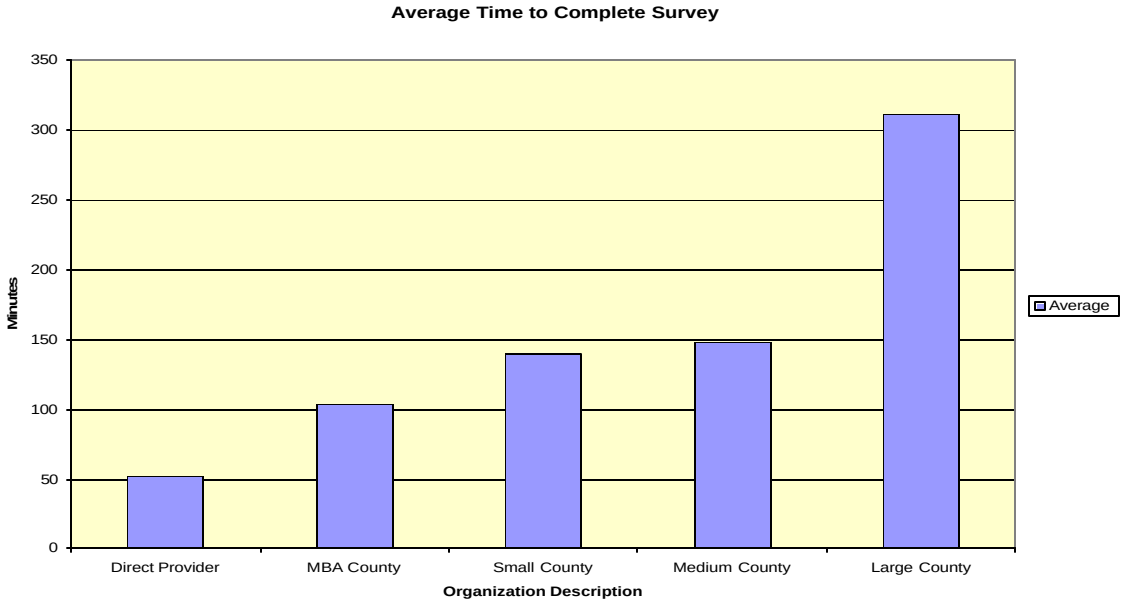
QUESTION 110 (87) – "Would you like to receive comparative results on this survey for like size counties?"

Many counties reported that they would be interested in receiving comparative survey results for like size counties.



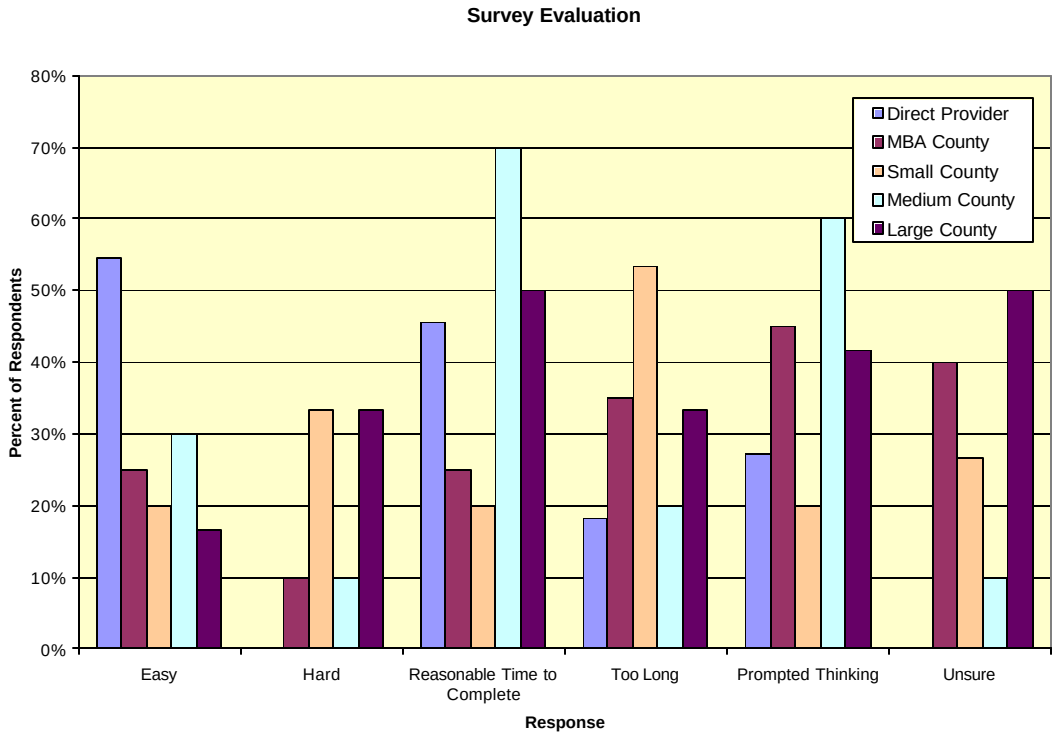
QUESTION 111 (88) – "How long did the survey take (in minutes)?"

As the size of the organization went up, the time it took to complete the survey also increased.


Average Time to Complete Survey
350
300
250
200
150
100
50
0
Minutes
Direct Provider
MBA County
Small County
Medium County
Large County
Organization Description
Average

QUESTION 112 (89) – "How would you rate this survey?"

The following graph shows the responses, broken out by county size and direct providers.



Summarized County Survey Results Report

This section contains summarized county responses for each survey question. Some questions, for example comment boxes, were not summarized and instead we indicated "NA for Summary". In some cases, the total, average, mode or median is shown, whichever is more appropriate for the question and the data. Please see the *Survey Results* section for definitions of these terms.

The summarized survey starts on the next page.

Assessment of Field Readiness for the California Outcomes Measurement System (CalOMS) (Treatment Only) Questionnaire RESULTS REPORT

Data Information

Group	Counties
Counties Reporting	57*

* Sutter-Yuba submitted combined results, therefore counting as 1

Overall CalOMS Concerns

1. Our county understands the data and operational requirements to implement CalOMS, as described by ADP as follows.

Count	
2	No knowledge of CalOMS requirements
22	Little knowledge of CalOMS requirements
27	Moderate knowledge of CalOMS requirements
6	Strong knowledge of CalOMS requirements

2. Our providers understand the data and operational requirements to implement CalOMS as follows. Select one.

Count	
20	No knowledge of CalOMS
20	Little knowledge of CalOMS
9	Medium knowledge of CalOMS
1	Strong knowledge of CalOMS
7	Do not know

3. Rank your five greatest concerns about implementing CalOMS, from 1 to 5. Rank your highest concern as a 1 lowest as a 5. No ties please.

Rank Count					***Category***
R1	R2	R3	R4	R5	
1	1	4	3	5	Staff qualifications and training needs
1	1	1	3	2	Use of ASI-Lite CF
4	2	4	5	7	Automated data submission requirements
8	6	11	8	6	Amount of data to be collected
31	11	3	1	1	Overall cost of implementation
7	20	14	6	4	Ongoing cost of administration/operation
7	7	7	5	2	Impact on client treatment
2	1	2	8	9	Locating client for follow-up assessment
1	0	3	7	6	Conducting follow-up assessment
2	5	4	4	8	Timeline of implementation
1	1	0	2	0	Client consent for follow-up
1	1	2	1	0	Client data confidentiality issues
1	0	0	1	3	Follow-up sampling procedures
3	0	2	1	4	Provider site abilities
0	0	0	0	0	Other:

***Comments*:**

4. Rank the county perceived benefits of CalOMS, from 1 to 5. Rank your highest anticipated benefit as a 1 lowest as 5. No ties please.

Rank Count					***Category***
R1	R2	R3	R4	R5	
19	10	6	4	3	CalOMS will provide valuable outcomes data.
0	3	0	1	4	CalOMS will provide my county leverage to broaden our use of ASI-Lite CF for outcomes measurement.
1	3	2	6	2	CalOMS will provide my county leverage to broaden our use of ASI-Lite CF for client assessment and treatment planning.
1	6	3	2	6	CalOMS will provide my county leverage to increase our automated data collection.
6	6	8	7	9	CalOMS will provide state and county comparison data.
12	10	10	2	4	CalOMS will help my county demonstrate effective use of treatment resources for grants and other future funding.
0	1	4	9	3	CalOMS will provide my county leverage to conduct follow-up assessments on clients for service planning.
8	8	13	8	3	CalOMS will provide data to improve services.
0	0	0	0	1	Other:
					None

5. Rate the perceived overall long-term benefits to AOD treatment that CalOMS will provide. Select one.

Count	***Benefit level***
7	The benefits of CalOMS significantly outweigh the anticipated work effort.
14	The benefits of CalOMS slightly outweigh the anticipated work effort.
7	The benefits of CalOMS are even with the anticipated work effort.
10	The benefits of CalOMS are slightly less than the anticipated work effort.
18	The benefits of CalOMS are significantly less than the anticipated work effort.

6. How much change to your county business processes do you foresee that you will need to make as a result of CalOMS? Select one.

Count	***Business process changes***
0	No business process changes are needed
0	Minimal business process changes are needed (0 – 5%)
7	Some business process changes are needed (6 – 10%)
38	Significant business process changes are needed (11-30%)
11	Fundamental business process changes are needed (over 31%)

7. How much change to your *contracted provider's* business processes do you foresee that they will need to make as a result of CalOMS? Select one.

Count	***Business process changes***
1	No business process changes are needed
2	Minimal business process changes are needed (0 – 5%)
3	Some business process changes are needed (6 – 10%)
22	Significant business process changes are needed (11-30%)
19	Fundamental business process changes are needed (over 31%)
8	Do not know

8. In order to implement CalOMS what do you project is the cost to your county in full-time staff equivalents (total in first year)? In monetary amount (total first year)?

	Total	Median
Full-time staff positions	101	2
Monetary amount	$5,691,499	$95,000

Do not know	24

9. In order to implement CalOMS what do you project is the cost to your *providers* in full-time staff equivalents (total in first year per provider)? In monetary amount (total first year per provider)?

	Total	Median
Full-time staff positions	375	3
Monetary amount	$12,848,179	$175,000

Do not know	36

10. Rate your county's and contracted provider's current level of readiness for CalOMS. Select one.

Count	***Readiness Level***
1	My county and contracted providers are ready – minimal effort is needed
13	My county and contracted providers are somewhat ready – some effort is needed
42	My county and contracted providers are not ready – significant effort is needed

11. Do you anticipate that your county will be ready for the October 2004 implementation date? Select one.

Count	***Ready by October 2004***
2	Definitely will be ready
13	Likely will be ready
24	May be ready
16	Unlikely will be ready
2	Definitely will not be ready

12. Do you anticipate that your providers will be ready for the October 2004 implementation date? Select one.

Count	***Ready by October 2004***
1	Definitely will be ready
8	Likely will be ready
15	May be ready
19	Unlikely will be ready
4	Definitely will not be ready
9	Do Not Know

13. If you do not anticipate complete readiness by October 2004, please specify a feasible alternate implementation date for your county, including providers.

	High	Mode	Average from 10/04 (months)
Projected Implementation date (mm/dd/yyyy)	10/1/2008	7/1/2005	9.8

14. What is your county and provider group's biggest barrier to achieving readiness:

***Barrier to Readiness*:**
NA For Summary

15. With which organizations does your county have previous outcomes studies experience? Check all that apply. If *Other*, please describe. If so, in what year?

Count	***Previous experience with outcomes studies***
17	No previous experience
22	UCLA
4	UCSD
2	UC Davis
1	CSU Bakersfield
1	RAND Corporation
18	SAMSHA
22	Other:

16. If you have additional overall concerns about CalOMS, please describe them here.

Additional Comments:
NA For Summary

Current information

17. The following lists treatment information ADP has about your county.[3] Please verify and correct this information, as necessary.

Category	***ADP information***	***Corrected information***
Annual admissions (for FY 01/02)[4]	NA For Summary	
Number of providers		
Average number of units (hours, visit day, bed day, slot day) per provider (for FY 00/01)		
Number of suspense errors as a % of submissions on CADDS (for FY 02/03)[5]		
% of CADDS admissions that go directly from providers to ADP for FY 01/02		

	Median
Turnaround time for error corrections (in months) for FY 01/02:	1

[3] From CADDS and cost reports

[4] Counts may include admissions from direct providers. The current list of direct providers was applied to all fiscal year data.

[5] Counts include transactions for direct providers. Direct providers are not uniquely identified for suspense reporting.

18. The following lists service type information ADP has about your county.[4] Please verify and correct this information, as necessary.

Service Type	***This service type is provided by county or by contract***		***If provided, approximate number of admissions for FY 01/02 (by service type)***[5]	
	ADP	*Corrected*	*ADP*	*Corrected*
Non-residential/outpatient				
Treatment/recovery	NA For Summary			
Day program-intensive				
Detoxification				
Residential				
Detoxification (hospital)	NA For Summary			
Detoxification (non-hospital)				
Treatment/recovery (30 days or less)				
Treatment/recovery (31 days or more)				
Methadone detoxification/maintenance				
Methadone detoxification - Methadone and/or LAAM	NA For Summary			
Methadone maintenance - Methadone and/or LAAM				

Administrative / County Contracts with providers

19. Are there providers in your county (other than direct providers) who do not report CADDS through the county, but report directly to ADP?

Count	
16	Yes
38	No

20. How many of your providers are:

	Number		***Percentage of Admissions***	
	ADP	*Corrected*	*ADP*	*Corrected*
Contracted providers:[6]	NA For Summary			

[6] From CADDS

County-operated providers:[4]	

If all of your services are delivered by county operated providers, skip questions 21 through 25.

21. What types of changes will you need to make to contracts with providers to accommodate CalOMS requirements? Mark all that apply.

Count	***Type of contract changes***
15	Client confidentiality
37	Client locator
41	Client follow-up
28	Informed consent
37	Data collection at admission/discharge
35	Data submission timeframes
35	Data submission methods
15	Staff classification and qualifications
17	Number of services provided to clients
13	Types of services provided to clients
9	Types of funding
19	Number of units
25	Data error thresholds
32	Timelines for data entry
5	Other:

Comments:

22. On average how long will the process take to implement these anticipated contract changes (span time in months)?

	Average	Median
Span time in months:	10	7

23. What types of changes will you need to make to your payment structure to accommodate CalOMS data collection?

Count	***Payment structure changes:***
30	Changes to the number of clients
11	Changes to the number of minutes per service
18	Changes to services
25	Changes to rates
6	Changes to staff classification
6	None

Comments:

24. Do you anticipate changing your contract amounts with various providers as a result of CalOMS? Select one.

Count	
22	Yes
9	No
21	Maybe

25. Do you see any impact of CalOMS data collection requirements on DMC claims?

Count	
23	Yes
23	No

If yes please explain:
NA For Summary

26. As a result of CalOMS, do you anticipate changes to the number of clients you will serve by service type? Mark one.

Count	
43	Yes
14	No

27. If Yes, please indicate changes anticipated by service type.

Service Type	***Count***		***Count***		***Avg Change***
	Yes	***No***	***+***	***-***	
Non-residential/outpatient					
Treatment/recovery	35	4	0	30	15.6
Day program-intensive	25	4	0	22	15.6
Detoxification	9	12	0	7	10.3
Residential					
Detoxification (hospital)	2	11	0	1	10.5
Detoxification (non-hospital)	17	11	0	13	25.2
Treatment/recovery (30 days or less)	25	6	1	19	21
Treatment/recovery (31 days or more)	22	7	0	20	18
Methadone detoxification/maintenance					
Methadone detoxification – Methadone and/or LAAM	5	13	0	3	18.8
Methadone maintenance – Methadone and/or LAAM	8	12	0	6	14.2

28. What magnitude of issues do you anticipate in establishing CalOMS in your county with the Board of Supervisors or your County Administrative Office? Mark one.

Count	***Funding***
4	No issues
24	Some issues
30	Major issues

Count	***Privacy***
21	No issues
33	Some issues
2	Major issues

Count	***Number of Clients Served***
8	No issues
22	Some issues
27	Major issues

Count	***Timeframe***
6	No issues
27	Some issues
24	Major issues

Count	***Administrative Time***
3	No issues
22	Some issues
31	Major issues

Count	***Staffing Issues***
2	No issues
24	Some issues
31	Major issues

Count	***Closure of Program***
22	No issues
23	Some issues
8	Major issues

29. Will your Board of Supervisors need to approve your plan before beginning implementation of CalOMS?

Count	
40	Yes

15	No

30. How much lead time (in months) do you anticipate needing to work with the Board of Supervisors or your County Administrative Office to begin to implement CalOMS?

	Average	Median
Span of time (of months):	6.3	6

Additional Comments:
NA For Summary

31. What do you need from ADP to address the Board of Supervisors or your County Administrative Office about CalOMS? Select all that apply.

Count	***Need from ADP***	
28	Emergency requirements regulations	
37	State contract change	
42	Opportunity to revise budget for SAPT monies	
28	New service codes for CalOMS activities	
17	Other:	

32. Since SAPT funds can be used to aid in implementation, will CalOMS requirements change how you planned to use 2003/2004 SAPT funds?

Count	
50	Yes
6	No

33. Are your SAPT funds sufficient to cover your expenses of initial implementation?

Count	
6	Yes
47	No

34. If SAPT funds are not sufficient to cover your expenses, what other revenue sources can you utilize? Select all that apply.

Count	**Other Revenue sources:**	
46	None	
2	Grants	
1	County Funds	
1	Endowments	
6	Other:	

Error correction

35. What is your process for correcting CADDS records? Select all that apply.

Count	**Error correction:**	
13	County Administrator fixes	
21	Delegate correction to provider	
20	Work with ADP to correct	
22	Send in hard copy correction	
36	Send in electronic correction	
2	Other:	

Admission/Intake

36. For what percentage of clients does your county or your provider group currently collect full Social Security Number (SSN) at admission or intake? Select one.

Count	***Percentage of clients that are required to report SSN***
5	Under 10%
1	11-30%
3	31-50%
5	51-70%
9	71-89%
31	Over 90%

37. Of those clients that you do attempt to collect the SSN, what percentage of clients refuse to provide? Select one.

Count	***Percentage of clients that do not provide SSN***
37	Under 10%
3	11-30%
1	31-50%
0	51-70%
1	71-89
0	Over 90%
12	Do not know

38. What reasons do clients most commonly give for refusal? Rank top 3.

Rank Count			***Why clients do not provide SSN***
R1	***R2***	***R3***	
4	7	7	Client has privacy concerns
14	6	5	Client does not know SSN
6	11	4	Client does not have a SSN
5	6	11	Client refuses, no reason given

2	0	0	Other:	
24			Do not know	

39. If not currently collected, do you anticipate barriers to collecting the SSN? Select one.

Count	***Barriers to collecting SSN***
16	Do not expect barriers collecting SSN
23	Expect some barriers collecting SSN
2	Expect many barriers collecting SSN
0	Will not be able to collect SSN

What types of barriers do you expect:
NA For Summary

40. Do you currently collect the following data items at admission or intake? Indicate yes or no for each data item.

Yes Count	***No Count***	***Data item***
39	12	Client's Birth Name
13	39	Mother's First Name
51	3	Client's Address

41. In addition to the current CADDS data elements, do you collect any of the following data at admission or intake? Select all that apply.

Count	***Question type***	
20	ASAM	
13	ASI-Lite CF	
32	Other ASI version	
23	Other:	

Addiction Severity Index (ASI)

42. For what percentage of your clients does your county require the use of the ASI (any version) during the course of treatment? Select one.

Count	***Percent of Required use of ASI***
8	None
5	Under 10%
7	11-30%
1	31-50%
7	51-70%
7	71-89
22	Over 90%

43. If you use the ASI (any version), do you calculate composite scores? Select one.

Count	
34	Yes
18	No

44. If you use the ASI (any version), do you calculate clinical factors? Select one.

Count	
34	Yes
18	No

45. If you do not use the ASI (any version) for all clients, what are the reasons? Select all that apply.

Count	***ASI usage***	
15	Not all of my county's providers use the ASI	
1	We use the ASI on a sample of our clients	
20	Not mandated	
12	Used only for specific funding sources	
12	Used only for specific client types	
14	Not applicable	
15	Other:	

46. If you use the ASI (any version), what percentage of the assessments is automated and what percentage is hard-copy?

Automated (entered and calculated in an automated system)	***Count***
% Range	
90-100	20
80-89	1
70-79	1
60-69	2
50-59	0
40-49	0
30-39	3
20-29	0
10-19	0
0-9 (MODE)	***30***

47. If you use the ASI (any version), what types of barriers do you experience in administering it?

Comments: NA for Summary

48. What are the benefits of using the ASI (any version)?

Comments: NA for Summary

49. What strategies or methods do you use or would you use to make it easier to implement and/or use the ASI (any version)? Select all that apply.

Count	***Easier to implement use of the ASI***
14	Financial incentives
8	Staff recognition
36	Automation of ASI
38	Training
9	Not applicable
7	Other:

50. If you don't use the ASI (any version), when do you plan to start to use it?

	Median
Projected ASI Implementation date: (mm/dd/yyyy)	8/1/2004

51. How long do you think it will take your county and contracted providers to implement the use of the ASI Lite CF (in months)?

	High	Low	Average	Median
Span of time in months:	24	1	8	6

Centralized Intake and Locator Information

52. For what percentage of your clients do you use centralized intake: Select one.

Count	***Percentage of clients using centralized intake***
15	Under 10%
7	11-30%
3	31-50%
4	51-70%
3	71-89
21	Over 90%

53. For what percentage of clients do you conduct the ASI at Central Intake: Select one.

Count	***Percentage of clients receiving ASI at intake***
25	Under 10%
5	11-30%
2	31-50%
2	51-70%
1	71-89
16	Over 90%

54. What percentage of your county's clients move between treatment services/sites within one service delivery experience? Select one.

Count	***Percentage of treatment moves***
17	Under 10%
24	11-30%
10	31-50%
4	51-70%
1	71-89
1	Over 90%

55. For what percentage of clients does your county or providers collect information that will allow you to locate a client after they leave treatment? Select one.

Percentage of clients for which we are currently collecting locator information	
Count	
9	None
9	Under 10%
5	11-30%
7	31-50%
5	51-70%
4	71-89
17	Over 90%

56. If so, what do you collect? Select all that apply.

Data item	
Count	
48	Client address
45	Client date of birth
49	Client telephone
8	Drivers License Number (DLN)
39	Social Security Number (SSN)
20	Backup contact name
24	Backup contact telephone
15	Backup contract address
7	Other:

57. If you currently collect locator information, when do you collect it? Select all that apply.

When collected	
Count	
43	Intake
26	Admission

18	During treatment	
14	Discharge	
3	Other:	

58. If you do not currently collect locator information, when do you plan to implement collecting client locator data?

	Median
Projected locator collection date: (mm/dd/yyyy)	10/1/2004

Client Case Management

59. What is your county's process for conducting client case management? Select all that apply.

Client Case Management methods	
Count	
48	Paper files
9	Custom automated solution
6	Standard (packaged) automated solution
5	Other:

60. What is your providers' process for conducting client case management? Select all that apply.

Client Case Management methods	
Count	
47	Paper files
9	Custom automated solution
6	Standard (packaged) automated solution
4	Other:
	Do not know

61. Do you coordinate client case management across different service delivery systems (e.g. mental health, social services, employment, etc.) in your county?

Count	
46	Yes
11	No

62. If yes, how do you coordinate client case management across different disciplines in your county? Select all that apply.

Client Case Management methods	
Count	
39	Paper files

4	Custom automated solution	
3	Standard (packaged) automated solution	
28	Staff assignment to integrate care	
11	Other:	

63. Has your county changed your case management approach due to SACPA?

Count	
25	Yes
32	No

Continuum of Care

64. What percentage of clients do you currently track from provider site to provider site within your county? Select one.

Percentage of clients are currently tracked between sites	
Count	
12	None
4	Under 10%
5	11-30%
4	31-50%
3	51-70%
6	71-89
20	Over 90%

65. If so, how do you do this? Mark all that apply. If "Other", please describe.

Method to track clients from site to site		
Count		
9	Social Security Number (SSN)	
23	County assigned unique identifier	
20	Paper files	
21	Staff follow-up	
9	Other:	

Discharge

66. How do you currently define discharge?

Discharge definition		
Count		
47	Using CADDS definition	
9	Final service same provider	
4	Funding source specific	
4	Definition provided by other or licensing requirements	
1	Do not know	
4	Other:	

Length of Stay

67. What percentage of your clients is in treatment after 6 months? Please correct the information supplied by ADP.

	Average	Mode
% of clients in treatment after 6 months:[7]	31.4	12

Follow-up

68. What percentage of your admissions does your county or provider group attempt to do follow-up contacts? Select one.

Follow-up contact percentage	
Count	
17	None
16	Less than 10%
12	11% – 50%
6	51% – 90%
3	Over 91%
1	Do not know

69. If applicable, when do you conduct the follow-up contact? Select all that apply.

When follow-up is conducted		
Count		
13	3 month post admission	
14	6 month post admission	
4	9 month post admission	
6	12 month post admission	
6	Do not know	
14	Other:	

70. If applicable, what percentage of your follow-up contacts are successful? (Successful = contacted client) Select one.

Follow-up contact percentage	
Count	
10	Less than 10%
18	11% – 50%
4	51% – 90%
0	Over 91%
10	Do not know

[7] From CADDS

71. If applicable, do you offer follow–up incentives to your clients? Select one.

Count	
5	Yes
36	No

72. If applicable, what type of follow–up contact do you complete? Select all that apply.

Follow-up contact type		
Count		
35	Telephone	
23	Letter	
18	In person	
3	Other:	

73. If applicable, who performs the follow-up work? Select all that apply. If other, please indicate method.

Follow-up work method		
Count		
20	Performed by county	
25	Performed by providers	
6	Contracted to external entity	
3	Other:	

74. If applicable, how long does the average follow-up process (i.e. from initial contact to attempt for follow-up to completing the follow-up assessment) take if the client is currently in treatment (span time in days)?

	Avg
Span time (days):	9.2

75. If applicable, on average, how much staff time does it take to conduct a follow-up interview, if the client is currently in treatment (staff time in minutes)?

	Avg
Staff time (minutes):	43.3

76. If applicable, how long does the average follow-up process take if the client is not in treatment (span time in days)?

	Avg
Span time (days):	18.5

77. If applicable, on average, how much staff time does it take to conduct a follow-up interview, if the client is not in treatment (staff time in minutes)?

	Avg
Staff time (minutes):	51.8

78. If applicable, what kind of instrument do you use for follow-up? Select all that apply.

Question type		
Count		
12	CADDS discharge	
4	ASI-Lite CF	
1	ASI-Lite CF subset	
4	Other ASI version	
5	Core Outcomes questions	
19	Client satisfaction questions	
16	Other:	

79. If applicable, what types of barriers do you experience in conducting follow-ups?

Comments: NA For Summary

80. What are the benefits of conducting follow-ups?

Comments: NA For Summary

81. What methods or strategies do you currently perform or think will help with get more participation in the follow-up process in your county? Select all that apply.

Implement use of the follow-up process		
Count		
23	Financial incentives for clients	
15	Staff recognition	
29	Reunions, parties or other gatherings for clients	
35	Ongoing contact with clients	
28	Training	
8	Other:	

82. How long do you estimate it will take you to locate your typical client and conduct a nine month follow-up interview as required by CalOMS?

	Avg
Span time (days):	14.5
Staff time (minutes):	124.8

83. CalOMS requires you to attempt nine-month follow-up interviews on a 10% sample of clients (assuming the minimum client population threshold for sampling is met). Do you plan to attempt nine-month follow-up interviews on more than 10%? Select one.

How many more clients will you follow-up on?	
Count	
27	No follow-up
12	Yes, less than 10% more
11	Yes, 11% – 50% more

1	Yes, 51% – 90% more
2	Yes, Over 91% more

84. Are you interested in participating in a county consortium for nine month follow-up interview sampling? (Small counties only).

Count	
24	Yes
18	No

Automated Systems

85. What percentage of CADDS admission records do you send to ADP in an automated format? *(County respondents: do not include your direct providers in your county.)* Please verify percentage shown.[8]

Percentage of CADDS transactions that are automated

Corrected Information	
Count	
11	No automation
0	1 - 10%
1	11-30%
1	31-50%
2	51-70%
1	71-89%
12	90-99%
29	100% automated

86. What systems do you use to collect and process client data?[9] Please correct if necessary. How many providers use each system? Please provide number.

	Use Count
System	
No automated system (hard-copy)	14
In-house county system	19
CADDS Access	13
CalTOP	2
Insyst ECHO system	18
AccuCare	10
DeltaMetrics	2
SRIS	13
DMC Billing	6

[8] From CADDS. Estimate based on number of hardcopy admissions submitted during fiscal year '01-'02.
[9] From CADDS

CMHC	10
Other third-party system	4
SAM	2
CSM	3
CBS	0

87. If other third-party system is used to collect and process CADDS data, please name vendor and system.

Vendor:	NA
System Name:	NA

88. How many full-time county Information Technology staff members do you currently employ?

	Mode
Number of IT staff:	0

89. How many systems do you expect to use for collecting and reporting data to ADP for CalOMS?

	Mode
Number of systems:	1

90. How much elapsed time do you estimate that it will take to modify these systems to meet CalOMS data collection requirements (in months)?

	Median
Elapsed time in months:	12

91. How many resources and how much of a financial investment do you anticipate it will require for you to analyze, design, develop and implement these system changes?

	Total	Mode
Full-time staff equivalents	40.4	1
Monetary amount	$5,154,160	$80,000

92. If you use outside vendors, how long will it take you to acquire resources to develop or modify automated tools (contract process)?

	Average
Elapsed time in months:	10

93. How many log identifications (users) will your county require for CalOMS (to send and receive data and reports)?

	Total	Average

Estimated Number of CalOMS logins:	1291	27

94. Do you currently use the Department of Mental Health's Information Technology Web Services (ITWS) for Department of Mental Health or CADDS data submission or ADP's DMC billing downloads? Mark one.

Count	
34	Yes
22	No

95. If you currently use the Department of Mental Health's Information Technology Web Services (ITWS), how many users do you have?

	Total	Avg
Actual number of ITWS users:	169	7

96. Are you interested in participating in a county consortium for development of an automated system (for any size county)?

Count	
40	Yes
13	No

Communication

97. What types of *regular* communication does your county have with your providers? Select all that apply.

	Communication method	***Frequency (monthly, weekly, quarterly, other)***
Count		
51	Face to face meetings	NA For Summary
49	Telephone calls	
11	Conference calls	
43	Email correspondence	
7	Newsletters	
13	Website information	
9	Association conferences	
8	Other:	

98. Are you satisfied with the level of communication you currently have with your providers? Select one.

Communication satisfaction	
Count	
1	Not satisfied
5	Minimally satisfied
41	Mostly satisfied
6	Completely satisfied

99. To enable us to coordinate future meetings, what types of *regular* communication does you county have with ADP? Select all that apply.

	Communication method	***Frequency (monthly, weekly, quarterly, other)***
Count		
30	Face to face meetings	NA For Summary
49	Telephone calls	
27	Conference calls	
50	Email correspondence	
34	Website information	
36	Training sessions	
51	Association conferences (such as CADPAAC)	
3	Other:	

100. Are you satisfied with the level of communication you currently have with ADP? Select one.

Communication satisfaction	
Count	
1	Not satisfied
10	Minimally satisfied
42	Mostly satisfied
5	Completely satisfied

Training Issues

101. How many total county staff do you anticipate will need to be trained on CalOMS/ITWS?

	Total
Estimated Number of CalOMS/ITWS users to train:	1147

102. How many county or provider staff will you need to train on using the ASI-Lite CF?

	Total
Estimated Number of users for initial ASI-Lite CF training:	3701
Estimated Number of users for an ASI-Lite CF refresher course	2009

103. How do you plan to train your staff on ASI-Lite CF process?
Select all that apply.

Training method	
Count	
37	On the job training
28	Group meetings
12	Video training
6	Electronically administered training (via CD or other media)
43	In house training (internal staff member will train remaining staff)
18	Outsourced training
7	Other:

Training comments:
NA For Summary

104. How many county or provider staff will you need to train on using the locator form?

	Total
Estimated Number of users for initial locator form training:	3822
Estimated Number of users for a locator form refresher course	1533
Do not know	13

105. How do you plan to train your staff on the locator form?
Select all that apply.

Training method	
Count	
38	On the job training
32	Group meetings
5	Video training
5	Electronically administered training (via CD or other media)
34	In house training (internal staff member will train remaining staff)
18	Outsourced training
7	Other:

Training comments:
NA For Summary

106. How many county or provider staff will you need to train on using the follow-up process?

	Total
Estimated Number of users for training who have never done follow-up:	1591
Estimated Number of users for training who have done follow-up:	710
Do not know	16

107. How do you plan to train your staff on the follow-up process?
Select all that apply.

Training method	
Count	
39	On the job training
34	Group meetings
4	Video training
6	Electronically administered training (via CD or other media)
37	In house training (internal staff member will train remaining staff)
19	Outsourced training
6	Do not know
5	Other:

Training comments: NA For Summary

Toolkit

108. What specific items would be helpful for ADP to provide in the field readiness assessment toolkit to be used by counties to help with CalOMS issues? Select all that your county would use.

Toolkit ideas		
Count		
30	Provider readiness assessment survey for counties to use	
49	Informed-consent boilerplate language	
47	Boilerplate contract language for providers	
49	Training materials on ASI-Lite CF	
54	Training materials/standards in client locating and follow-up methods	
44	Information on software availability and licensing issues	
35	Information on establishing consortiums for software development	
34	Information on establishing consortiums for follow-up assessment	
45	Informative materials on CalOMS for providers	
55	Sample implementation plan	
47	HIPAA privacy and security information	
6	Other:	

109. Please provide other toolkit ideas:

Comments:
NA For Summary

Survey feedback

110. Would you like to receive comparative results on this survey for like size counties?

Count	
52	Yes
3	No

111. How long did this survey take (in minutes)?

	Avg
Span time (minutes):	165

112. How would you rate this survey? Select all that apply.

Survey comments	
Count	
13	It was easy to complete.
12	It was hard to complete.
21	It took a reasonable amount of time.
21	It took too long to complete.
23	It prompted my county to think about CalOMS.
19	My county is not sure of the purpose of some of the questions.

Comments

Summarized Direct Provider Survey Results Report

This section contains summarized direct provider responses for each survey question. Some questions, for example comment boxes, were not summarized and instead we indicated “NA for Summary”. In some cases, the total, average, mode or median is shown, whichever is more appropriate for the question and the data. Please see the *Survey Results* section for definitions of these terms.

The summarized survey starts on the next page.

Outcomes Measurement System (CalOMS) (Treatment Only) Questionnaire

For general instructions for completion of this survey, please refer to the instructions titled "Assessment of Field Readiness for the California Outcomes Measurement System Questionnaire – Instructions".

Data Information

Group	Direct Providers
Direct Providers Reporting	11

Overall CalOMS Concerns

1. Our organization understands the data and operational requirements to implement CalOMS, as described by ADP as follows. Select one.

Count	
1	No knowledge of CalOMS requirements
4	Little knowledge of CalOMS requirements
5	Moderate knowledge of CalOMS requirements
1	Strong knowledge of CalOMS requirements

2. Rank your five greatest concerns about implementing CalOMS, from 1 to 5. Rank your highest concern as a 1 lowest as a 5. No ties please.

Rank Count					***Category***
R1	R2	R3	R4	R5	
0	1	3	0	0	Staff qualifications and training needs
0	0	1	0	0	Use of ASI-Lite CF
2	1	0	0	0	Automated data submission requirements
0	2	4	0	0	Amount of data to be collected
2	5	2	1	0	Overall cost of implementation
0	2	1	1	1	Ongoing cost of administration/operation
1	1	0	1	0	Impact on client treatment
0	2	1	0	1	Locating client for follow-up assessment
0	1	0	0	0	Conducting follow-up assessment
4	0	1	0	2	Timeline of implementation
0	0	1	0	0	Client consent for follow-up
1	0	0	4	0	Client data confidentiality issues
0	1	0	1	4	Follow-up sampling procedures
0	0	0	2	0	Provider site abilities
0	0	0	0	1	Other:

***Comments*:**
NA For Summary

3. Rank your perceived benefits of CalOMS, from 1 to 5. Rank your highest anticipated benefit as a 1 lowest as 5. No ties please.

Rank Count					***Category***
R1	R2	R3	R4	R5	
4	4	1	0	0	CalOMS will provide valuable outcomes data.
0	1	0	0	0	CalOMS will provide leverage to broaden our use of ASI-Lite CF for outcomes measurement.
0	1	0	0	1	CalOMS will provide leverage to broaden our use of ASI-Lite CF for client assessment and treatment planning.
0	0	1	0	2	CalOMS will provide leverage to increase our automated data collection.
0	0	1	1	1	CalOMS will provide state and county comparison data.
2	0	2	1	0	CalOMS will help me demonstrate effective use of treatment resources for grants and other future funding.
0	1	2	1	0	CalOMS will provide leverage to conduct follow-up assessments on clients for service planning.
2	0	2	1	0	CalOMS will provide data to improve services.
0	0	0	0	0	Other:
5					None
1					Do not know

4. Rate the perceived overall long-term benefits to AOD treatment that CalOMS will provide. Select one.

Benefit level	
Count	
3	The benefits of CalOMS significantly outweigh the anticipated work effort.
0	The benefits of CalOMS slightly outweigh the anticipated work effort.
1	The benefits of CalOMS are even with the anticipated work effort.
0	The benefits of CalOMS are slightly less than the anticipated work effort.
7	The benefits of CalOMS are significantly less than the anticipated work effort.

5. How much change to your business processes do you foresee that you will need to make as a result of CalOMS? Select one.

Business process changes	
Count	
0	No business process changes are needed
0	Minimal business process changes are needed (0 – 5%)
6	Some business process changes are needed (6 – 10%)
5	Significant business process changes are needed (11-30%)
0	Fundamental business process changes are needed (over 31%)

6. In order to implement CalOMS what do you project is the cost to your organization in full-time staff equivalents (total in first year)? In monetary amount (total first year)?

	Count	Median
Full-time staff positions	14	.625
Monetary amount	$313,760	$16,750

Do not know	4

7. Rate your current level of readiness for CalOMS. Select one.

Readiness Level	
Count	
0	My organization is ready – minimal effort is needed
2	My organization is somewhat ready – some effort is needed
9	My organization is not ready – significant effort is needed

8. Do you anticipate that your organization will be ready for the October 2004 implementation date? Select one.

Ready by October 2004	
Count	
2	Definitely will be ready
1	Likely will be ready
3	May be ready
1	Unlikely will be ready
4	Definitely will not be ready

9. If you do not anticipate complete readiness by October 2004, please specify a feasible alternate implementation date for your organization.

	High	Mode	Average from 10/04 (months)
Projected Implementation date (mm/dd/yyyy)	7/1/2005	7/1/2005	7.6

10. What is your organization's biggest barrier to achieving readiness:

***Barrier to Readiness*: NA For Summary**

11. With which organizations do you have previous outcomes studies experience? Check all that apply. If *Other*, please describe. If so, in what year?

	Previous experience with outcomes studies	
Count		
3	No previous experience	
6	UCLA	
1	UCSD	
0	UC Davis	
0	CSU Bakersfield	
1	RAND Corporation	
4	SAMSHA	
1	Other:	

12. If you have additional overall concerns about CalOMS, please describe them here.

Additional Comments:
NA For Summary

Current information

13. The following lists treatment information ADP has about your organization.[10] Please verify and correct this information, as necessary.

Category	***ADP information***	***Corrected information***
Annual admissions (for FY 01/02)	NA For Summary	
Number of providers		
Average number of units (hours, visit day, bed day, slot day) per provider (for FY 00/01)		
Number of suspense errors as a % of submissions on CADDS (for FY 02/03) **(County only)**		

	Median
Turnaround time for error corrections (in months) for FY 01/02:	1

[10] From CADDS and cost reports

14. The following lists service type information ADP has about your organization.[4] Please verify and correct this information, as necessary.

Service Type	***This service type is provided by provider***		***If provided, approximate number of admissions for FY 01/02 (by service type)***	
	ADP	*Corrected*	*ADP*	*Corrected*
Non-residential/outpatient				
Treatment/recovery	NA For Summary			
Day program-intensive				
Detoxification				
Residential				
Detoxification (hospital)	NA For Summary			
Detoxification (non-hospital)				
Treatment/recovery (30 days or less)				
Treatment/recovery (31 days or more)				
Methadone detoxification/maintenance				
Methadone detoxification - Methadone and/or LAAM	NA For Summary			
Methadone maintenance - Methadone and/or LAAM				

Administrative

15. Do you see any impact of CalOMS data collection requirements on DMC claims?

Count	
3	Yes
5	No

If yes please explain:
NA For Summary

16. Do you foresee fiscal implications from implementing CalOMS?

Count	
8	Yes
1	No

17. As a result of CalOMS, do you anticipate changes to the number of clients you will serve by service type? Select one.

Count	
1	Yes
10	No

18. If Yes, please indicate changes anticipated by service type.

	Count		***Count***		***Avg Change***
Service Type	***Yes***	***No***	***+***	***-***	
Non-residential/outpatient					
Treatment/recovery	1	0	0	1	15
Day program-intensive	0	0	0	0	0
Detoxification	0	0	0	0	0
Residential					
Detoxification (hospital)	0	0	0	0	0
Detoxification (non-hospital)	0	0	0	0	0
Treatment/recovery (30 days or less)	0	0	0	0	0
Treatment/recovery (31 days or more)	0	0	0	0	0
Methadone detoxification/maintenance					
Methadone detoxification – Methadone and/or LAAM	0	0	0	0	0
Methadone maintenance – Methadone and/or LAAM	0	0	0	0	0

19. In how many counties are you required to report CADDS data, either through the county or as a direct provider?

	Count
Number of counties as direct provider:	7
Number of counties we report through county:	4

Error correction

20. What is your process for correcting CADDS records? (Select all that apply)

Error correction:	
Count	
0	County fixes
1	Delegate correction to provider
2	Work with ADP to correct
8	Send in hard copy correction
0	Send in electronic correction

1	Other:	

Admission/Intake

21. For what percentage of clients does your organization currently collect full Social Security Number (SSN) at admission or intake? Select one.

Percentage of clients that are required to report SSN	
Count	
1	Under 10%
0	11-30%
0	31-50%
0	51-70%
3	71-89%
7	Over 90%

22. Of those clients that you do attempt to collect the SSN, what percentage of clients refuse to provide? Select one.

Percentage of clients that do not provide SSN	
Count	
8	Under 10%
1	11-30%
0	31-50%
0	51-70%
0	71-89
1	Over 90%
0	Do not know

23. What reasons do clients most commonly give for refusal? Rank top 3.

Rank Count			***Why clients do not provide SSN***	
R1	R2	R3		
7	0	1	Client has privacy concerns	
2	2	0	Client does not know SSN	
0	0	2	Client does not have an SSN	
0	4	4	Client refuses, no reason given	
0	3	1	Other:	
0			Do not know	

24. If not currently collected, do you anticipate barriers to collecting the SSN? Select one.

Barriers to collecting SSN	
Count	
2	Do not expect barriers collecting SSN
6	Expect some barriers collecting SSN
1	Expect many barriers collecting SSN
0	Will not be able to collect SSN

What types of barriers do you expect:
NA For Summary

25. Do you currently collect the following data items at admission or intake? Indicate yes or no for each data item.

Yes Count	No Count	
		Data item
10	1	Client's Birth Name
7	4	Mother's First Name
11	1	Client's Address

26. In addition to the current CADDS data elements, do you collect any of the following data at admission or intake? Select all that apply.

Mark if Yes	***Question type***	
Count		
0	ASAM	
1	ASI-Lite CF	
1	Other ASI version	
8	Other:	

Addiction Severity Index (ASI)

27. For what percentage of your clients do you require the use of the ASI (any version) during the course of treatment? Select one.

Percent of Required use of ASI	
Count	
8	None
0	Under 10%
0	11-30%
0	31-50%
0	51-70%

0	71-89
3	Over 90%

28. If you use the ASI (any version), do you calculate composite scores? Mark one.

Count	
3	Yes
5	No

29. If you use the ASI (any version), do you calculate clinical factors? Mark one.

Count	
3	Yes
5	No

30. If you do not use the ASI (any version) for all clients, what are the reasons? Select all that apply.

ASI usage		
Count		
0	We use the ASI on a sample of our clients	
2	Not mandated	
0	Used only for specific funding sources	
0	Used only for specific client types	
2	Not applicable	
6	Other:	

31. If you use the ASI (any version), what percentage of the assessments is automated and what percentage are hard-copy?

Automated (entered and calculated in an automated system)	***Count***	
Percentage Automated		
100	1	
0	10	(Mode)

32. If you use the ASI (any version), what types of barriers do you experience in administering it?

Comments:
NA For Summary

33. What are the benefits of using the ASI (any version)?

Comments:
NA For Summary

34. What strategies or methods do you use or would you use to make it easier to implement and/or use the ASI (any version)? Select all that apply.

Easier to implement use of the ASI	
Count	
1	Financial incentives
1	Staff recognition
3	Automation of ASI
5	Training
1	Not applicable
4	Other:

35. If you don't use the ASI (any version), when do you plan to start to use it?

	Median
Projected ASI Implementation date: (mm/dd/yyyy)	1/1/2004

36. How long do you think it will take your organization to implement the use of the ASI Lite CF (in months)?

	High	Low	Median
Span of time in months:	6	1	3

Centralized Intake and Locator Information

37. What percentage of your organization's clients move between treatment services/sites within one service delivery experience? Select one.

Percentage of treatment moves	
Count	
8	Under 10%
1	11-30%
0	31-50%
0	51-70%
0	71-89
2	Over 90%

38. For what percentage of clients does your organization collect information that will allow you to locate a client after they leave treatment? Select one.

Percentage of clients for which we are currently collecting locator information	
Count	None
0	Under 10%
0	11-30%
0	31-50%
0	51-70%

1	71-89
10	Over 90%

39. If so, what do you collect? Select all that apply.

Data item	
Count	
11	Client address
11	Client date of birth
11	Client telephone
8	Drivers License Number (DLN)
11	Social Security Number (SSN)
11	Backup contact name
11	Backup contact telephone
10	Backup contract address
1	Other:

40. If you currently collect locator information, when do you collect it? Select all that apply.

When collected		
Count		
11	Intake	
3	Admission	
3	During treatment	
4	Discharge	
0	Other:	

41. If you do not currently collect locator information, when do you plan to implement collecting client locator data?

	Median
Projected locator collection date: (mm/dd/yyyy)	Not Answered

Client Case Management

42. What is your process for conducting client case management? Select all that apply.

Client Case Management methods	
Count	
11	Paper files
1	Custom automated solution
0	Standard (packaged) automated solution
0	Other:

43. Do you coordinate client case management across different service delivery systems (e.g. mental health, social services, employment, etc.) for your clients?

Count	
5	Yes
6	No

44. If yes, how do you coordinate client case management across different disciplines for your clients? Select all that apply.

Client Case Management methods		
Count		
4	Paper files	
0	Custom automated solution	
0	Standard (packaged) automated solution	
2	Staff assignment to integrate care	
0	Other:	

45. Have you changed your case management approach due to SACPA?

Count	
1	Yes
9	No

Discharge

46. How do you currently define discharge?

Discharge definition		
Count		
4	Using CADDS definition	
6	Final service same provider	
2	Funding source specific	
3	Definition provided by other or licensing requirements	
1	Do not know	
1	Other:	

Length of Stay

47. What percentage of your clients is in treatment after 6 months? Please correct the information supplied by ADP.

	Corrected
	Mode
% of clients in treatment after 6 months:[11]	80

[11] From CADDS

Follow-up

48. What percentage of your admissions does your organization attempt to do follow-up contacts? Select one.

Follow-up contact percentage	
Count	
1	None
1	Less than 10%
1	11% – 50%
5	51% – 90%
3	Over 91%
0	Do not know

49. If applicable, when do you conduct the follow-up contact? Select all that apply.

When follow-up is conducted		
Count		
9	3 month post admission	
7	6 month post admission	
2	9 month post admission	
2	12 month post admission	
1	Do not know	
1	Other:	

50. If applicable, what percentage of your follow-up contacts is successful? (Successful = contacted client) Select one.

Follow-up contact percentage	
Count	
5	Less than 10%
4	11% – 50%
2	51% – 90%
0	Over 91%
1	Do not know

51. If applicable, do you offer follow–up incentives to your clients? Select one.

Count	
3	Yes
8	No

If applicable, what type of follow–up contact do you complete? Select all that apply.

Follow-up contact type		
Count		
11	Telephone	
3	Letter	
3	In person	
0	Other:	

52. If applicable, who performs the follow-up work? Select all that apply. If other, please indicate method.

Follow-up work method		
Count		
0	Performed by county	
11	Performed by our organization	
1	Contracted to external entity	
0	Other:	

53. If applicable, how long does the average follow-up process (i.e. from initial contact attempt for follow-up to completing the follow-up assessment) take if the client is currently in treatment (span time in days)?

	Average	Median
Span time (days):	2.8	1

54. If applicable, on average, how much staff time does it take to conduct a follow-up interview, if the client is currently in treatment (staff time in minutes)?

	Average	Median
Staff time (minutes):	28.5	12.5

55. If applicable, how long does the average follow-up process take if the client is not in treatment (span time in days)?

	Average	Median
Span time (days):	18.3	1

56. If applicable, on average, how much staff time does it take to conduct a follow-up interview, if the client is not in treatment (staff time in minutes)?

	Average	Median
Staff time (minutes):	30.5	20

57. If applicable, what kind of instrument do you use for follow-up? Select all that apply.

Question type	
Count	
3	CADDS discharge
1	ASI-Lite CF
0	ASI-Lite CF subset
1	Other ASI version
1	Core Outcomes questions
9	Client satisfaction questions
6	Other:

58. If applicable, what types of barriers do you experience in conducting follow-ups?

Comments:
NA For Summary

59. What are the benefits of conducting follow-ups?

Comments:
NA For Summary

60. What methods or strategies do you currently perform or think will help with get more participation in the follow-up process in your county? Select all that apply.

Implement use of the follow-up process	
Count	
8	Financial incentives for clients
3	Staff recognition
4	Reunions, parties or other gatherings for clients
5	Ongoing contact with clients
10	Training
0	Other:

61. How long do you estimate it will take you to locate your typical client and conduct a nine month follow-up interview as required by CalOMS?

	Average	Median
Span time (days):	15.3	7
Staff time (minutes):	47.8	30

62. CalOMS requires you to attempt nine-month follow-up interviews on a 10% sample of clients (assuming the minimum client population threshold for sampling is met). Do you plan to attempt nine-month follow-up interviews on more than 10%? Select one.

How many more clients will you follow-up on?	
Count	
1	No follow-up
2	Yes, less than 10% more
6	Yes, 11% – 50% more
1	Yes, 51% – 90% more
1	Yes, Over 91% more

63. Are you interested in participating in a direct provider consortium for nine month follow-up interview sampling?

Count	
9	Yes
2	No

Automated Systems

64. What percentage of CADDS admission records do you send to ADP in an automated format? Please verify percentage shown.[12]

Percentage of CADDS transactions that are automated

Corrected Information	
Count	
9	No automation
0	1 - 10%
0	11-30%
0	31-50%
0	51-70%
0	71-89%
0	90-99%
1	100% automated

[12] From CADDS. Estimate based on number of hardcopy admissions submitted during fiscal year '01-'02.

65. What systems do you use to collect and process client data?[13] Please correct if necessary.

System	***Use Count***
No automated system (hard-copy)	9
In-house county system	1
CADDS Access	2
CalTOP	0
Insyst ECHO system	1
AccuCare	0
DeltaMetrics	0
SRIS	0
DMC Billing	4
CMHC	0
Other third-party system	1
SAM	0
CSM	0
CBS	0

66. If other third-party system is used to collect and process CADDS data, please name vendor and system.

Vendor:	NA For Summary
System Name:	

67. How many full-time Information Technology staff members do you currently employ?

	Average	Mode
Number of IT staff:	1.2	1

68. How many systems do you expect to use for collecting and reporting data to ADP for CalOMS?

	Average	Mode
Number of systems:	1.4	1

69. How much elapsed time do you estimate that it will take to modify these systems to meet CalOMS data collection requirements (in months)?

	Average	Median
Elapsed time in months:	3.6	2

[13] From CADDS

70. How many resources and how much of a financial investment do you anticipate it will require for you to analyze, design, develop and implement these system changes?

	Total	Average	Mode
Full-time staff equivalents	9.5	1.2	.25
Monetary amount	$540,000	$67,500	$7,000

71. If you use outside vendors, how long will it take you to acquire resources to develop or modify automated tools (contract process)?

	Average
Elapsed time in months:	7

72. How many log identifications (users) will you require for CalOMS (to send and receive data and reports)?

	Total
Estimated Number of CalOMS logins:	18

73. Do you currently use the Department of Mental Health's Information Technology Web Services (ITWS) for Department of Mental Health or CADDS data submission or ADP's DMC billing downloads? Select one.

Count	
6	Yes
5	No

74. If you currently use the Department of Mental Health's Information Technology Web Services (ITWS), how many users do you have?

	Total
Actual number of ITWS users:	40

75. Are you interested in participating in a direct provider consortium for development of an automated system?

8	Yes
2	No

Communication

76. To enable us to coordinate future meetings, what types of *regular* communication does your organization have with ADP? Select all that apply.

	Communication method	***Frequency (monthly, weekly, quarterly, other)***
Count		
3	Face to face meetings	NA For Summary
11	Telephone calls	
4	Conference calls	
4	Email correspondence	
3	Website information	
3	Training sessions	
2	Association conferences (such as CADPAAC)	
0	Other:	

77. Are you satisfied with the level of communication you currently have with ADP? Select one.

Communication satisfaction	
Count	
0	Not satisfied
2	Minimally satisfied
6	Mostly satisfied
3	Completely satisfied

Training Issues

78. How many staff do you anticipate will need to be trained on CalOMS/ITWS?

	Total	Avg
Estimated Number of CalOMS/ITWS users to train:	76	7

79. How many staff will you need to train on using the ASI-Lite CF?

	Total
Estimated Number of users for initial ASI-Lite CF training:	81
Estimated Number of users for an ASI-Lite CF refresher course	45

80. How do you plan to train your staff on ASI-Lite CF process?
(Select all that apply)

Training method	
Count	
9	On the job training
4	Group meetings
2	Video training
2	Electronically administered training (via CD or other media)
5	In house training (internal staff member will train remaining staff)
4	Outsourced training
1	Other:

Training comments:
NA For Summary

81. How many total staff will you need to train on using the locator form?

	Total
Estimated Number of users for initial locator form training:	76
Estimated Number of users for a locator form refresher course	21
Do not know	3

82. How do you plan to train your staff on the locator form?
(Select all that apply)

Training method	
Count	
8	On the job training
3	Group meetings
2	Video training
2	Electronically administered training (via CD or other media)
4	In house training (internal staff member will train remaining staff)
4	Outsourced training
1	Other:

Training comments:
NA For Summary

83. How many staff will you need to train on using the follow-up process?

	Total
Estimated Number of users for training who have never done follow-up:	40
Estimated Number of users for training who have done follow-up:	11
Do not know	4

84. How do you plan to train your staff on the follow-up process?
(Select all that apply)

Training method	
Count	
9	On the job training
3	Group meetings
2	Video training
2	Electronically administered training (via CD or other media)
4	In house training (internal staff member will train remaining staff)
3	Outsourced training
2	Do not know
0	Other:

Training comments:
NA For Summary

Toolkit

85. What specific items would be helpful for ADP to provide in the field readiness assessment toolkit to be used by counties and direct providers to help with CalOMS issues? Select all that your organization would use.

Toolkit ideas	
Count	
3	Provider readiness assessment survey for counties to use
8	Informed-consent boilerplate language
9	Boilerplate contract language for providers
11	Training materials on ASI-Lite CF
11	Training materials/standards in client locating and follow-up methods
11	Information on software availability and licensing issues
10	Information on establishing consortiums for software development
9	Information on establishing consortiums for follow-up assessment
10	Informative materials on CalOMS for providers
10	Sample implementation plan
10	HIPAA privacy and security information
5	Other:

86. Please provide other toolkit ideas:

Comments:
NA For Summary

Survey feedback

87. Would you like to receive comparative results on this survey?

Count	
10	Yes
1	No

88. How long did this survey take (in minutes)?

	Average
Span time (minutes):	52

89. How would you rate this survey? Select all that apply.

Survey comments	
Count	
6	It was easy to complete.
0	It was hard to complete.
5	It took a reasonable amount of time.
2	It took too long to complete.
3	It prompted my organization to think about CalOMS.
0	My organization is not sure of the purpose of some of the questions.

Comments
NA For Summary

Individual Readiness Assessment Results

This section contains the individual county (and direct provider) readiness assessments. This section is intentionally left blank to accommodate requests for confidentiality. ADP intends to distribute individual readiness assessments to respective county and direct providers.